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THE USE OF PATIENTS IN GRADUATE TEACHING IN PSYCHIATRY*

BY SANDOR RADO, M.D., D.Pol.Sc.

Although graduate psychiatric education varies widely from place to place,** the topic assigned to the present writer for discussion—the use of patients in teaching—calls for a definite frame of reference. The over-all plan of instruction upon which this presentation will be based is indicated in Tables 1 to 4.

Table 1. Formal Organization†

Graduate Psychiatric Education is divided into two stages:
1. ***Basic Curriculum.*** Embraces the entire field of psychiatry. Requires two years and is combined with residency in a mental hospital.
2. ***Advanced Curricula.*** (Upon completion of the basic curriculum.) Specialized in the following areas:
(1) Research psychiatry
(2) Administrative psychiatry (hospital and community)
(3) Medical psychotherapy including medical psychoanalysis
(4) Child psychiatry
(5) Psychiatry for the aging
Stage 2 is combined with work at a psychiatric institution. Depending upon the area, the advanced curricula require from 1 to 3 years.

In the present context, Table 1 requires no comment. In Table 2, Points 1 and 2 are far from being generally recognized. Table 3 features a problem of overriding importance. The basic sciences of psychiatry—a loose collection of self-contained and overspecialized disciplines—are less and less capable of capturing the organizational complexity of human behavior. The psychiatrist must cull the information he needs from this collection of disciplines, each systematized for its own particular purpose; he must then

*From The New York School of Psychiatry. Read at the Teaching Institute of the American Psychiatric Association, held under the aegis of McGill University, October 10-11, 1958, Montreal.

**For background information, see Whitehorn (Ref. 1).

†The formal organization outlined here is based on a draft prepared by this writer in 1956 for the graduate education of state mental hospital resident physicians at the former School of Graduate Psychiatry, operated jointly by the State University of New York and the New York State Department of Mental Hygiene during the academic years 1956-57 and 1957-58. The responsibilities of this school were taken over by The New York School of Psychiatry, chartered by the regents of the University of the State of New York, and established September 1, 1958.

Table 2. Phases of Instruction

1. Psychodynamic sensitization: training in self-awareness and emotional resonance.
2. Utilization of the student psychiatrist's own life experience as a psychiatric resource.
3. Supervised work with patients in hospitals and clinics: examination, observation, diagnosis, treatment, recording.
4. Laboratory techniques for the analysis of behavior. The human organism is viewed here as a biological system interacting with the cultural system that surrounds it.
5. Theoretical instruction: classroom exposure, demonstrations, books. (See Tables 3 and 4.)

Table 3. Stages of Psychiatric Theory

Descriptive Stage: The Clinical Pictures of Behavior Disorders	→ ←	*Analytic Stage*: Comprehensive Dynamics of Healthy and Disordered Behavior

try to integrate the heterogeneous pieces of knowledge from the *behavioral* point of view—in any way he can. But this effort is frustrated in short order by the fact that the so-called "mind-body relation" is still enveloped in a blanket of fog.

Table 4 seeks to clear the road to a realistic treatment of this problem. Psychiatric authors use, not infrequently in the same sentence, a mixture of two languages, one inspectional or physical, and the other, introspectional or psychological. The terms of the former are reducable to measurement by yardstick and clock; those of the latter are not. Technical epistemologists, while critical of this inconsistency, have so far offered no workable alternative, probably because they lack familiarity with the empirical subject-matter of psychiatric endeavor. What we need is obviously a logically consistent conceptual scheme, one that is suited for the description and explanation of the phenomena of *psychiatric* clinical observation. A theory built of high level abstractions (formal analogies, verbal identities, and so on), even if admirable, can hardly be expected to produce logical consequences that could fertilize the *psychiatric* domain of empirical inquiry.

Table 4. Toward the Construction of a Comprehensive Dynamics of Human Behavior

1. Investigation of the organism from within, employing the language and conceptual scheme of *communicated introspection*:

Psychodynamics of Behavior deals with the part played in the organization of behavior by mechanisms of motivation and control. To be supplemented by an ancillary science—sociological psychodynamics—dealing with the societal mechanisms of motivation and control.

2. Investigation of the organism from without, employing the language and conceptual scheme of *inspection*:

Physiodynamics of Behavior: the part played in the organization of behavior by physiological (biophysical, biochemical, pathological) and genetic mechanisms.

3. Establishment of introspectional-inspectional correlations: *physiological psychodynamics.* Comparative epistemological, linguistic and psychodynamic exploration of the two conceptual schemes, preparatory to the construction of a consistent theory.

In its entirety, the scheme of comprehensive dynamics outlined here seeks to trace the essential determinants (structures, relations, processes) of healthy and disordered behavior through the levels of molecule, cell, organ, organ-system, individual, family, other social groups, mankind as a whole, to the emerging integrated patterns of transordinal interaction.

Though often enough simply taken for granted, the psychiatric use of a mixed language is sometimes defended on grounds that our introspectional and inspectional findings are felt to be concordant. This argument confuses intuition with concepts. Science is composed of concepts, and the harmony it seeks is known as logical consistency.

Approaching the problem at the common-sense level, one can see that the two languages of psychiatry differ from each other in perceptual basis, range of referents and functional organization. These differences have been neglected. If we are to attain our objective, we must first of all explore the differences, their nature and causes. For this purpose, wherever feasible, psychiatrists should be encouraged to team up with such other experts as the job requires. And the students should be kept in touch with this enterprise from the outset. In this day and age science ought not to be handed down to them like a ready-made product; they should partake in its making precisely at the point where

our need for fresh ingenuity is the greatest. Meanwhile, one must seek to establish at least gross correlations that would link findings of the introspectional type to those of the inspectional type.

Viewing the topic in this perspective, one sees that, in teaching, it is necessary to use patients for no less than eight purposes, listed in Table 5.

Table 5. Use of Patients in Teaching

Preparatory Instruction:
1. Mutual sensitization of physician and patient to motivational awareness.
Theoretical instruction:
2. Basic science demonstrations (including psychodynamics).
3. Demonstration of clinical pictures.
Clinical Instruction:
4. Psychiatric examination.
5. Demonstration of treatment procedures.
6. Conferences: Presentation, for discussion, of patients on admission, under treatment, on discharge.
7. Supervised diagnostic and treatment work at out-patient clinics.
8. Supervised diagnostic and treatment work at hospitals.

Brief comment on each of the Table 5 items follows.

Point 1. Undergraduate instruction in medical schools is of necessity grounded in the physiological sciences whose outlook and procedures the student thus comes to identify with the scientific method. This is true even if the curriculum offers him opportunity to acquire a smattering of psychodynamics. When the young physician enters upon graduate psychiatric education, he is as a rule committed to the *inspectional* approach. Interviewing psychiatric patients, he will either stick to the descriptive level—as did, for instance, no lesser men than Emil Kraepelin and Adolf Meyer—or he will understand their motivation precisely to the same extent as he understands people in daily life. Unfortunately for him, as Freud has demonstrated, behavior disorders are dominated by *hidden* motivation. Aspiring young men discover this fact, and turn to Freud's theories—including those which are by now superannuated. However, the fact is that the student, no matter how much he has read, cannot possibly disclose the patient's hidden motivation unless he has first learned to understand his own hidden motivation. The ideal way of doing this is for the

student to undergo psychoanalytic treatment himself, provided the procedure pursues its originally intended goals of emotional maturation and intellectual potentiation—rather than being deliberately or unwittingly conducted as a course of emotionally reinforced indoctrination with the doctrines of no matter how great an authority. Unpleasant though it is to discuss this subject, the writer feels strongly that educational experience of decades must not be withheld from our younger confreres. They should realize that undergoing preparatory psychoanalytic treatment (so-called "training analysis") is a step requiring the utmost circumspection; because, depending upon the "training-psychoanalyst's" theoretical outlook and technique, the procedure *can* work in reverse, binding the student with strong emotional ties to the *un*scientific method—perhaps for the rest of his life. Aside from this danger, it is a practical impossibility to have all student psychiatrists undergo psychoanalytic treatment. As an alternative, the writer has suggested* that they be *sensitized* to motivational understanding by *training in self-awareness.* By means of such training, introspection can be raised to the level of a scientific method. The student can learn how to relax his precautionary mechanisms which ordinarily control the entrance of thought into consciousness; how to discriminate between, and trace the motivating action of, his emotional experiences; how to distinguish emotional thought from unemotional (unbiased) thought; how to increase his intellectual powers by focusing his attention on the abstractive process; and so on. Furthermore, in order to advance from introspection (self-observation) to an introspectional understanding of the patient, the student will have to develop his native capacity for what the writer calls emotional resonance.[3] This, in his opinion, is our biological tool for the perception—empathic grasp—of the patient's emotional motivation.

At the former State University School of Graduate Psychiatry (recently replaced by The New York School of Psychiatry) for the last two years we have given instruction of this type in the classroom. Since the intelligent patient's motivational awareness must also be raised to a higher level for therapeutic reasons, one can evolve a procedure of mutual sensitization which includes in-

*The concept of "psychodynamic sensitization" was introduced by the writer in a statement in Alexander's *Psychoanalysis and Psychotherapy.* (Ref. 2.)

terviewing, by the student psychiatrist in front of the class, of a properly selected patient for this particular purpose.

While its technical procedures are still in the experimental stage, psychodynamic sensitization can considerably deepen the student's understanding of himself, of the theories of psychodynamics, and of his patients—thereby making him a better psychotherapist. How the well-sensitized student could in addition be helped to open up his own life experience as a psychiatric resource, is still an unsolved problem.

Point 2. In the past, separation of theoretical from clinical instruction has been carried to an extreme, obscuring the fact that, in medicine, theories derive from clinical observation and must, in turn, be validated by clinical observation. Therefore, it is desirable, as far as possible, to illustrate lectures on even the physiological basic sciences by the presentation of patients. In theoretical lectures on psychodynamics this is an indispensable procedure.

The writer would like to add a word about psychodynamics. In this young branch of human biology, no general agreement has yet been reached. If psychodynamics is to guide the psychiatrist in all phases of clinical work, its theories must remain close to the phenomena of actual observation and must be stated in unequivocal language that makes it possible to verify, refute or modify them on grounds of observational evidence. The revised system of psychoanalytic thought called adaptational psychodynamics is the outcome of a sustained effort to meet these elementary requirements of the scientific method.[4] The same is true of the adaptational technique of psychoanalytic therapy.

Point 3 is self-explanatory.

Point 4. The way the student psychiatrist examines his patients offers the first opportunity to evaluate his native endowment, as well as the results of his preliminary sensitization. He may show an increasing grasp of hidden motivation; or may remain at the daily-life-level of motivational understanding; or may stick to the descriptive level; or may reveal that saturation with inadequate theories has rendered him incompetent for true clinical observation.

Though the substance of *Points* 5 through 8 is self-explanatory, a few supplementary statements are in order.

Psychiatry is that branch of medicine which is concerned with the investigation and treatment of the diseased "psyche"—that is, of behavior disorders. Consequently, in the last analysis, psychiatric treatment is psychotherapy, even if our remedial measures include pharmacological, electrical, surgical or other procedures. Regardless of whether the physician realizes this or not, all procedures in all medicine work within a psychotherapeutic framework.

The author classifies the methods of psychotherapy as reconstructive, quasi-reconstructive and reparative. The adaptational technique of psychoanalytic therapy is a reconstructive method. Employing the medical technique of *emotional learning and unlearning*, it *can* lift the patient's life performance to the mature level. Though the therapeutic goal of reconstruction through reeducation was first envisaged by Freud, closer examination shows that his own original technique of psychoanalytic therapy can only be classified as quasi-reconstructive because it is in its entirety based upon the patient's emotional dependence on the physician, the so-called positive transference. The reparative methods include hypnosis, supportive, trouble-shooting, easing and other procedures. Every psychiatrist must have a full command of, at minimum, all reparative methods. Specialization in psychoanalytic therapy requires completion of an advanced graduate curriculum. Nevertheless, even if the psychiatrist does not specialize in psychoanalysis, he should have a crystal-clear idea of the psychodynamic principles underlying the different forms of psychoanalytic therapy, and should understand their mode of action, their indications and contraindications. He should know just as much about full-fledged psychoanalytic therapy as a good neurologist knows about neurosurgery, or a good internist about thoracic and abdominal surgery. He need not be left uninformed, seeing in psychoanalysis a glorified or inglorious mystery, as the case may be. In the province of medicine, psychoanalysis can no more claim the privilege of extraterritoriality than any other branch of knowledge or specialized skill.

More than 10 years ago at the Columbia University Psychoanalytic Clinic,* the writer instituted the practice of having the student psychoanalyst interview psychoanalytic patients at the

*The writer was in charge of the Columbia University Psychoanalytic Clinic for Training and Research from its establishment in 1944 until 1955.

various stages of treatment in front of the class. The patients had been advised on admission that they would have to appear at such conferences as a part of the clinic's treatment procedure. No ill effects to a patient have ever been observed. Once the patient has been presented in person, subsequent reports on his progress can be presented and discussed over a period of time. But the continued discussion of psychoanalytic patients whom no one except the therapist himself has ever seen is an inadequate educational procedure.

There is no reason why such demonstrations should not occasionally also be given in the course of the basic curriculum; that is, before an audience of student psychiatrists, some of whom will not specialize in psychoanalysis.

At the same time, another innovation was introduced at the Columbia clinic; the supervising psychoanalyst was required to examine personally every patient treated by the student psychoanalyst, preferably in the latter's presence. The practice of supervising the psychoanalytic treatment of a patient whom the supervisor has never seen is inadequate.

The fundamentals of psychotherapy must be taught with patients suffering from psychoneuroses—the overreactive and mood-cyclic disorders of the adaptational classification. Here the task is to improve the patient's adaptation to his life circumstances. But in the treatment of the schizotypal disorders, one is forced to pursue a different goal in two consecutive steps. In these disorders, one has the stage of compensation, from which the pathological process may progress to decompensation (pseudoneurotic stage), to disintegration (overt psychotic episode or stage of adaptive incompetence) and to deterioration.[5-8] Therefore, the first step is to bring the patient back to the compensated stage by seeking to adapt the environment to his needs. The second step, then, is to allay his fears of what he experiences as his adaptive limitations, and teach him how to avoid the danger of decompensation by learning to live with himself and make appropriate use of his inner resources. Accordingly, in the case of the hospitalized patient, one must attempt to create a hospital milieu that will place upon him the minimum environmental stress. In recent years, it has been shown in hospitals here and abroad that an enlightened hospital setting can transform the classical pictures of schizophrenia to an extent that has never before been anticipated. The changes

are even more impressive if regulation of the hospital environment is combined with the administration of psychoactive drugs and other therapeutic procedures. To go beyond the goal of restoring the patient to the compensated stage, will become possible only when the biological etiology of the disorder is more adequately known.

During the teaching of the psychiatric aspect of comprehensive medicine, the student psychiatrist is brought into contact with patients in all branches of medicine. Collaboration with the general practitioner and the various medical specialists, however, is a problem whose discussion would fill a paper by itself.

Concerning students' work at out-patient clinics and hospitals, the writer has had to leave unmentioned still other innovations and experiments; but this topic too must await another occasion.

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PROMAZINE IN THE MANAGEMENT OF THE TUBERCULOUS, MENTALLY-ILL PATIENT*

BY HARRY B. LUKE, M.D.

The control, management, and treatment of the mentally ill patient is difficult. Even more difficult to control, manage, and treat, is the mentally ill patient who has tuberculosis.

At the time of admission of such a patient to the hospital, the tuberculosis usually is active, and special medication and therapy, which require patient-co-operation are necessary. Before the development of the ataractics, electric shock therapy and prefrontal lobotomy were employed; however, many patients could not be controlled by the use of these procedures.

The introduction of ataractic agents led to considerable promise of improvement in the management of these patients. The use of reserpine and chlorpromazine was helpful in making them co-operative for treatment; however, frequent incidents of unpleasant, if not dangerous, side effects and reactions occurred in these physically and chronically depleted individuals.

Promazine, one of the more recently introduced ataractic agents, has been reported by numerous investigators to be effective in the management of the mentally ill patient, and is described as lacking the pronounced depressive and other undesirable activities associated with the use of chlorpromazine.[1-3]

Although the references in the literature for the effective use of promazine in the management of the mentally ill patient are profuse,[4-10] there is a paucity of information about its use in the management of the mentally ill patient who has tuberculosis.[10, 11]

Because of the excellent results reported for patients who were mentally ill, it was proposed, in the investigation reported here, to determine the efficacy of promazine hydrochloride in the management of mentally ill patients suffering from tuberculosis.

Method

On admission to the hospital, the 97 patients, 40 men and 57 women, who were the subjects of this study, had either active or inactive tuberculosis concomitant with various acute and chronic mental disturbances. Seven patients had additional complicating

*From Pilgrim State Hospital, West Brentwood, N. Y.

illnesses such as arteriosclerotic heart disease, obstructive jaundice, and allergic urticaria. The age range of these patients was from 23 to 73; the mean age was 50.5 years (Table 1). The psy-

Table 1. Ages of 97 Patients Treated With Promazine

Age Range	Number			Percentage
	Men	Women	Total	
23-29	2	3	5	5.2
30-39	4	10	14	14.4
40-49	9	14	23	23.7
50-59	17	15	32	33.0
60-69	7	12	19	19.6
70-73	1	3	4	4.1
	40	57	97	100.0

Table 2. Psychiatric Diagnostic Categories

Diagnoses	Number		
	Men	Women	Total
Group I			
Schizophrenia	32	41	73
Hebephrenic	3	8	11
Catatonic	5	14	19
Paranoid	24	19	43
Group II			
Psychosis	8	11	19
with syphilis of CNS	3	2	5
with mental deficiency	1	3	4
caused by alcohol	2	1	3
with epilepsy	1	0	1
with psychopathic personality	0	1	1
with cerebral arteriosclerosis	0	1	1
with infectious diseases	0	1	1
Involutional (melancholia)	0	1	1
Involutional (paranoid)	0	1	1
Senile (paranoid type)	1	0	1
Group III			
Miscellaneous	1	4	5
Psychoneurosis (hypochondriasis)	0	1	1
Manic-depressive psychosis	0	2	2
Mental deficiency	1	0	1
Mental deficiency with mental disorder	0	1	1
Total	40	57	97

chiatric diagnostic categories represented are presented in Table 2. The psychiatric symptoms present are given in Table 3.

Reserpine, chlorpromazine, and prochlorperazine had been included in the medication used in previous routine patient management at Pilgrim. In many instances, however, the occurrence of side effects (such as parkinsonism, jaundice, and allergies) and the absence of results, or both, warranted the discontinuance of these agents.

Of the 97 patients, 47 received from 50 to 300 mg. of promazine* orally per day; 50 patients received from 400 to 900 mg. daily. In six patients, an increase in the initial daily dose of from 50 to 450 mg. per day was required. In 13 patients, a decrease in the initial dose of from 100 to 700 mg. per day was found possible. The duration of medication was from seven days to 11 months; the average duration of medication was 9.3 months.

Table 3. Psychiatric Symptoms Present in 97 Patients

MOOD:		AWARENESS:	
Appropriate	3	Confused	4
Inappropriate	15	Superficial	3
Exhilarated	10	Perplexed	21
Euphoric	5	FEELING:	
Demonstrative	5	Panicky	3
Flat	31	Tense	7
HOSTILITY REACTIONS:		Hypersensitive	5
Destructive	13	Dull	38
Belligerent	22	RESPONSIVITY:	
Self-effacing	1	Flexible	9
Suicidal	2	Negativistic	51
SPEECH:		SEXUAL BEHAVIOR:	
Overtalkative	7	Homosexual	1
Mute	3	Masturbatory	1
EATING HABITS:		PERCEPTION:	
Refusing	10	Hallucinated	17
APPEARANCE:		Deluded	17
Bizarre	1	Hallucinated and Deluded	39
Neat	4		
Untidy	5		
MOTOR ACTIVITY:			
Excited	16		
Agitated	28		
Active	4		
Quiet	5		
Stuporous	1		

*"Sparine," from Wyeth Laboratories, Inc., Philadelphia, Pa.

Fourteen patients received adjunctive medication which included methylphenidate hydrochloride (eight patients), chlorpromazine hydrochloride (one), diphenylhydantoin sodium and phenobarbital (two), prochlorperazine (one), iproniazid (one), and methylphenidate hydrochloride and reserpine (one). In addition to promazine and the medication just mentioned, 74 patients had standard therapy for tuberculosis.

Electric shock therapy was not administered to any of these patients during promazine medication. One patient in the group had had a lobotomy before the administration of promazine.

The scale in Table 4 was used by the examining psychiatrist in

Table 4. Results of Promazine Therapy by Diagnostic Category

Diagnoses	Excellent	Good	Moderate	None	Total Patients
Group I					
Schizophrenia	5	15	31	22	73
Hebephrenic	0	3	5	3	11
Catatonic	1	5	8	5	19
Paranoid	4	7	18	14	43
Group II					
Psychosis	1	2	12	4	19
with syphilis of CNS	0	0	5	0	5
with mental deficiency	0	1	2	1	4
caused by alcohol	0	1	2	0	3
with epilepsy	1	0	0	0	1
with psychopathic personality	0	0	1	0	1
with cerebral arteriosclerosis	0	0	0	1	1
with infectious diseases	0	0	0	1	1
Involutional (melacholia)	0	0	1	0	1
Involutional (paranoid)	0	0	0	1	1
Senile (paranoid type)	0	0	1	0	1
Group III					
Miscellaneous	0	2	2	1	5
Psychoneurosis (hypochondriasis)	0	1	0	0	1
Manic-depressive psychosis	0	1	1	0	2
Mental deficiency	0	0	0	1	1
Mental deficiency without mental disorder	0	0	1	0	1
Total	6	19	45	27	97

determining the results of promazine therapy: Response to therapy was considered *Excellent* when there was a remission of psychotic symptoms and a return to the prepsychotic level. *Good* indicated a remission of psychotic content, including delusions and hallucinations, but with some behavior abnormality remaining. *Moderate* showed that the psychotic content was mostly retained but that behavior was much improved. *None* indicated that there was no response to therapy. See Table 4.

Results

Of the 97 patients who received promazine therapy, 70 (72 per cent) had some response to medication; 27 (28 per cent) had none. Of the 70 patients who showed improvement, the response was *excellent* in six, *good* in 19, and *moderate* in 45. The results obtained by individual groups are presented in Table 4.

In the patients (47) who received between 50 and 300 mg. of promazine daily, the response was *excellent* in four, *good* in 11, and *moderate* in 19. Thirteen patients in this group failed to respond to therapy.

Of the patients (50) who received between 400 and 900 mg. of promazine daily, excellent results were obtained in two, good results in eight, and moderate results in 26. Fourteen failed to respond to therapy.

The response to increased medication in six patients who had *moderate* (five) or *good* (one) responses to the initial medication resulted in improvement in two (*moderate* to *good*). The responses were unchanged on the rating scale for the remaining four patients in this group.

Responses to decreased medication in 13 patients who had *moderate* (eight), *good* (four), or *no response* (one) to the initial medication resulted in improvement in two (*moderate* to *good*), and poorer responses in three (*moderate* to *none* in two patients, and *good* to *moderate* in one). The responses for the remaining eight patients were not altered by the decrease in the amount of medication.

In the 14 patients who received additional adjunctive drugs, the response was *excellent* in two, *good* in two, and *moderate* in eight. Two patients, one who received methylphenidate and one who received chlorpromazine, did not respond to therapy.

Eight patients were discharged from the hospital. Only two of the patients on convalescent care required medication: One patient received 200 mg. of promazine at bedtime; the other received 100 mg. of promazine, three times per day. One patient, not included in the eight discharged from the hospital, was slated to go on convalescent care but was happy where she was and refused to leave the hospital.

Side effects occurred in nine patients: parkinsonism (one), skin allergy (four), jaundice (one), edema of the leg (one), vomiting (one), and leucopenia (one). Seven of the nine patients in whom side effects developed had previously been on chlorpromazine therapy, reserpine therapy, or both.

Summary

Ninety-seven patients who had either active or "arrested" tuberculosis concomitant with various acute and chronic mental disturbances received promazine therapy. Of the 97 patients, 74 also received standard therapy for tuberculosis, and 14 received additional adjunctive medication in the form of methylphenidate hydrochloride, chlorpromazine, diphenylhydantoin sodium, phenobarbital, prochlorperazine, iproniazid, or reserpine. In the whole group, the response to medication was *excellent* in six, *good* in 19, and *moderate* in 45. Twenty-seven patients did not respond to therapy.

During promazine therapy, the tuberculous patients responded to the program of bed rest. Those patients who formerly had refused to submit to enforced quiescence were better adjusted to the required restrictions. There also was marked relief from the nausea and vomiting usually associated with standard therapy for tuberculosis. In not one instance, were there adverse effects on the disease, or antagonism to other medication given concomitantly with promazine.

It is the writer's impression that, although promazine may require a slightly longer time to obtain clinical response than some ataractic agents, it appears to have fewer unpleasant side effects. Promazine appears to be a very useful drug in the management of tuberculous, mentally-ill patients.

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DIAGNOSIS OF AMBULATORY SCHIZOPHRENIA: A CASE STUDY*

BY HAROLD BESSELL, Ph.D., AND VINCENT E. MAZZANTI, M.D.

It is the purpose of this paper to show how an ambulatory schizophrenic can go for many years seeking and receiving medical treatment and yet never be accurately diagnosed until this ambulatory schizophrenic process is specifically looked for. To illustrate this point, the case has been chosen of a 44-year-old man seen in a Veterans Administration mental hygiene clinic. This patient, far from being an unusual case, typifies a common diagnostic problem which has been observed for many years at the Wichita and Topeka Veterans Administration mental hygiene clinics.

The veteran, S., was born in 1912. When he was eight, his father died. His mother is still living. S. was raised in a small town. He started going with girls at the age of 12 and reported having his first intercourse at that age He has never told of having any nervous habits as a child, and he reported that he had smoked and drunk only very moderately at any time in his life. When he was going to high school, he raised chickens, trapped and hunted, usually alone. At the age of 19, he went to live with an aunt in another state, and shortly thereafter had a succession of jobs of a menial nature, for example, washing cars and performing janitorial work. He reported that at that time he would get tired of a job after a month or so and would quit, and that he, therefore, traveled around the country a great deal.

S. was married at 24 to a woman six years older than himself. They have no children and they have now been married more than 20 years. His longest job before enlisting in the army at the age of 31 was for two years as an office boy. In the service he had the duties of a clerk-typist and also led a chorus and taught some classes in typing. He achieved the grade of T-4.

Soon after his entrance into service in January 1943, he began attending sick call frequently. He complained of pains and stiffness in his left leg and hip. In giving the history of his complaints, he said he had first experienced this difficulty in 1938 when he had numbness and pain in his left ankle as if he had sprained

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it. He said he had paid no attention to it for several days, and that then, one evening as he was playing cards, he suffered a sudden cramping or stiffness of his whole leg and had to be carried home. He remained in bed for two or three weeks and gradually recovered the use of his leg; but he was on crutches and a cane for some months; and it was a couple of years before he felt that he was fully recovered. After repeated examinations, the army doctors decided that *no organic basis* for any of his complaints could be found.

In April 1943, S. was transferred to Georgia, where he felt the climate was very damp and where he experienced a recurrence of the aching and stiffness in his left leg. At that time, he also reported that when the weather got cold his left hip became stiff. Medical examinations made at this time showed *no organic basis* for the complaints.

Upon arrival overseas in September 1943, S. continued frequent attendance at sick call and complained, at different times, of dizzy spells, legs swelling, pains in his leg, inability to sit or stand without excessive pain, headaches, irritation from the noise of airplanes, poor memory, difficulty in concentrating, migrating joint-pains of the lower and upper extremities, fever and swollen joints. *Again, no organic basis could be found for any of these complaints.*

In February 1944, he reported to sick call complaining of occasional dizzy spells, especially when sitting down or getting up suddenly. He said that he had arthritis and that when he had to march his legs swelled up and became painful. He complained of dizziness when standing in formation, and his medical officer told him not to stand in formation, take exercises or march. Three weeks later, he again complained of being unable to stand or sit without excessive pain. He was sent to the hospital by his company commander, who refused to permit him to stay on duty. During the second week of his hospitalization, the patient reported some improvement. He was then sent to another general hospital where he stayed for a week; but at this hospital he complained that the bad weather and the outdoor work and rehabilitation exercises which were required of him increased his pain. He was sent to Scotland and permitted to remain indoors, and he reported that he was doing "just fine" there. He was returned to the United States in July 1944, and reported that he felt pretty good at that time. Soon after, however, he reported to sick call, complaining

of joint pains, swelling in his ankles, poor memory, and what appeared to be postural vertigo. *No organic basis could be found for any of these complaints,* and he was referred for psychiatric examination. The psychiatrist described the patient as cheerful, pleasant and willing to return to his clerical duties. He also remarked that the patient's civilian history had indicated mild general inadequacy and occupational instability. He was diagnosed as psychoneurosis, hypochondriasis. When he was referred for another psychiatric examination two months later, this psychiatrist stated that the patient was "trying to create an impression of potential mental illness."

Finally, in May 1945, the patient received an examination and it was stated, "He cannot adjust to army life. He does not like the army very well." He was given an honorable CDD.

After receiving his CDD in 1945, he attended a university under the GI bill, at one time stating his objective was to become a teacher and at another time to specialize in social science. In the middle of 1947, he had intermittent periods of being confined to bed for a few weeks at a time because of his various aches and pains. He also had difficulty in concentrating, got increasingly nervous, and could not tolerate noise at all. At that time he also reported a decrease in sexual desires. The patient told his training officer he did not know what he was training himself for, and he finally decided to quit school. In 1947, after a periodic psychiatric examination for compensation purposes, it was stated, "He has no insight into his condition, judgment is impaired, and he is quite dependent upon his wife. There is much secondary gain through being taken care of by his wife and the receipt of compensation." He was diagnosed as neurasthenic. Between 1947 and 1949, he had numerous odd jobs of a menial nature. In December 1949, a private psychiatrist, who had been providing the patient with fee basis treatment for six months for his nervousness, stated, "Mr. S. has made a great deal of improvement and is now free from most of his complaints."

Between 1950 and 1954, the man was employed as a night watchman. This was the longest job he ever had. He quit because he "got tired of being up all night." He worked briefly for the post office department as a clerk in 1955 and then obtained a job as a filing clerk. In May 1955, a special psychiatric examination for rating purposes, made by the Veterans Administration, in-

dicated that he was employed for $2,750 a year and that he had missed two months of work in the past 12 months because of illness. This report further stated, "The veteran is well oriented in all spheres and in good contact with reality. No thought disorder appears to be present. Friendly throughout. Gives information very slowly and in a very vivid manner. He presents himself as a rather resigned, passive, forlorn individual. He is extremely dependent upon his wife and frequently stated that his wife could answer questions better than he could. *Physical complaints appear to be almost entirely on a psychoneurotic basis.*" He was diagnosed as psychoneurosis, neurasthenia, moderately severe.

Up to this point, the history is that of a man who has presented a large variety of medical, and some psychological, complaints over a period of 17 years. There were 527 pages in his Veterans Administration claim file and treatment folder. Certainly this man must have been having more than usual difficulty to have sought so long and so often for some understanding and treatment for something which was bothering him. And surely there must be some explanation of the fact that, repeatedly, no organic basis could be found for his medical complaints. He had repeatedly met with admonition and indifference. Still, requesting medical attention was the only way the patient knew he could have another try at getting help. Is it really sufficient to call this condition hypochondriacal neurosis and let it go at that because a man repeatedly seeks attention? And, further, is it sufficient to diagnose the patient as neurotic in the absence of some demonstration of what the neurotic conflict is?

The patient was referred to a mental hygiene clinic in 1955 for the first time, after 17 years of complaining and evidently gaining little satisfaction. It became the clinic's task to learn what was behind his many complaints and bids for treatment. His claims file and treatment folder were read, he was interviewed for a social history and was given a battery of psychological tests, following which he was assigned to a therapist. On a cross-sectional basis there was nothing so unusual about any of his complaints at any given time; especially if one considers that the complaints were given by a fine-looking man, well dressed, intelligent, polite, superficially co-operative and never openly challenging what was given him. Evaluation of the history recorded in his claim file showed that no medical condition and no convincing

psychological conflicts have ever been identified. A longitudinal evaluation, however, alerts one to the fact that there is much about this patient that is unusual.

His history had the following elements: (1) the absence of a positive medical diagnosis or treatment alleviating the presented complaints; (2) an unstable work history with frequent job change and considerable loss of time from work; (3) the frequent employment in menial tasks of a person intellectually capable of much better performance; (4) a generally passive mode of adjustment; (5) a marriage to an appreciably older woman; (6) poor accountability for major decisions (e.g., he quit his job and joined the army because he was "sick and unable to work"); (7) the presence of such psychological complaints as difficulty in concentrating, poor memory, nervousness, inability to tolerate noise, and confusion over his training objective; (8) psychiatric evaluation as having no insight, impaired judgment, and being dependent upon his wife, and as having mild general inadequacy. Further, at one point, he was considered to be "trying to create an impression of potential mental illness."

His composite picture in many ways resembled the history of many ambulatory schizophrenics the writers have seen in the past 10 years; and they, therefore, were alerted to the possibility that this man, too, might be an ambulatory schizophrenic.

Now the problem became one of specifically exploring this possibility. In his interview with the psychiatric social worker, it was observed that the patient avoided dealing with details. He denied that he had any problems that needed to be worked out, indicated that he was just interested in receiving medicine, and, in general, gave the impression that he was perhaps overly cautious about bringing things into the open. Further, he stated that he could not tolerate noise and said that it did "something" to him but that it didn't make him feel "radical."

When he appeared for psychological examination, it was noted that he showed no overt anxiety and manifested flattened affect. He was resistant to taking the Rorschach and denied many responses immediately after giving them. Many other responses were vague and poorly differentiated: "just one big splotch of ink with junk around it," "looks like somebody spilled a bottle of ink," and "that doesn't look like anything; when I look at it long enough it disappears." Other responses were indicative of guardedness

and concealed pathology; e.g., "turtle," "lock," "mask," and "owl" (perhaps a symbol of knowing more than he tells). Other responses were carefully framed to be neutral and innocuous. On the Sentence Completion Test some of his responses were: confusion "about everything"; "people think of me as 'being a little off' sometimes"; and "my worst fault is knowing things that no one else does."

The claims folder made the examiners alert to the possible diagnosis; the social history interview increased the suspicion; psychological tests, although not definitive, were more suggestive. S. was assigned to a therapist, one of the purposes being to explore the extent of the psychopathology further.

The patient was given regular appointments weekly for therapy interviews. His physical complaints were listened to, explored in detail by questioning, and given full recognition. He was told that it certainly was strange that nothing could ever be found to show what was causing all these physical aches, and he remarked conversationally that there were plenty of strange things that happened. His therapist picked up this lead and asked the patient to tell him about these other strange things. S. told the therapist that he had had a funny experience in which he had a vision that there was a penny lying on a street corner on his way to work. The next morning, he went by this corner, and, sure enough, there was the penny. He picked it up and went on to work.

Reassured by the accepting reception of this disclosure, S. went on to say that when he was overseas he had a vision of an obese cousin who was lying emaciated in a coffin. Sure enough, when he returned from overseas one of the first things that happened was that he attended her funeral; and there she was, just as he had seen her in the vision. While he was at the funeral, her brother walked by; and as he did, a voice told the patient, "He is next." Sure enough, three months later he was dead, too. The patient went on to tell that when he first returned home from overseas he would meet people in the street who knew him but whom he did not recognize. He said he would pretend that he knew them and then when he got home, he would ask his wife who they were. Still another experience was that of a voice telling him at work that somebody was going to die. Three days later, one of his

co-workers reported that her husband had just died. The patient was able to tell all of this after four psychotherapy interviews.

After this sequence, the patient has told innumerable such strange experiences during a year of coming for psychotherapy interviews. Recently he has told that a voice said to him, "Mary done you wrong." After stating this, the patient remarked, "Who the heck is Mary?" He also reports that the voice tells him, "I have been looking after you all your life," and "You are going to write a book." He says, "By avoiding people they don't tell me I make crazy remarks and don't laugh at me for talking to myself."

There is, of course, at this time no doubt about the diagnosis of this man. Not only has he documented the fact well that he has been an ambulatory schizophrenic for the past 17 years, but he has given many indications that he has been having hallucinatory experiences as far back in his childhood as he can remember.

Discussion and Summary

It has been the writers' experience that ambulatory schizophrenics may cover up their true pathology for many years unless this condition is both specifically looked for as a diagnostic possibility, and the therapist, through interest and acceptance, makes it possible for the patient to tell him the true nature of his pathology. The present case is illustrative of a frequent problem in patients seen in the last 10 years at the Wichita and Topeka Veterans Administration mental hygiene clinics.

If the diagnosis did not point the way to appropriate treatment, it certainly would make little difference whether an accurate diagnosis were made. However, the treatment for hypochondriacal neurosis and that for ambulatory schizophrenia are vastly different. With this patient, after he had been accurately diagnosed, more appropriate plans could be made about treatment. After this patient had been in treatment for a year, it was observed that he had not requested or needed appointments in the other departments.

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PSYCHIATRY IN GREAT BRITAIN TODAY. II*

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NOTE: *A group of informative lectures (Parts I and II of this paper) was presented by Dr. Cecil Beresford, physician-superintendent of The Retreat in York, England, to the staff of the New York Hospital—Westchester Division in October 1958. There has been a close association between the English and New York hospitals since their earliest days. Thomas Eddy, who became a governor of the New York Hospital in 1793, took a great interest in the more enlightened and humane treatment of the mentally ill in England and France than prevailed in this country. He was particularly impressed by the good effects of the treatment procedures at The Retreat in York, founded by William Tuke and brought before the public through the writings of the founder's grandson, Samuel Tuke, particularly the* Description of The Retreat, *published in 1813, a work which had wide influence in the establishment of other institutions and in reforming psychiatric treatment policies.*

Thomas Eddy was immediately impressed and in 1815 advocated the founding of a psychiatric service where the newer forms of treatment, then known as moral management, could be instituted. By moral management was meant the humane, kindly treatment of the patient in as rational a manner as his state of mind would allow, the elimination of all force and restraint up to the point of safety, the use of physiotherapy, occupational therapy, diversion, recreation, regular religious services of all faiths, social events, dances, music and reading—the therapeutic measures spoken of today as program therapies.

The separate psychiatric service of the New York Hospital, established on the present site of Columbia University in New York City in 1821, was known as Bloomingdale Asylum. The name

*Part I of this paper, Sections I and II (the first two of Dr. Beresford's four lectures at New York Hospital—Westchester Division) appeared in the April 1959 issue of THE PSYCHIATRIC QUARTERLY. Part II, presented herewith, is made up of sections III and IV (the third and fourth lectures) and concludes the series.

was later changed to Bloomingdale Hospital which, in 1894, was moved to White Plains, N. Y. The name of the hospital was changed to the New York Hospital—Westchester Division in 1936 in order to convey a clearer understanding than had hitherto prevailed of the relation of the hospital in White Plains (in Westchester County) to the Society of the New York Hospital.

Through the years, the governors and physicians of the two institutions have corresponded and visited, with resulting mental stimulation. Recently both hospitals have become more fully involved with the mental health needs of their local communities in the operation of out-patient service and through programs of teaching and research.

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III. Physical Treatment in British Mental Hospitals

It is only fair to say at once that there is little new to report in the way of physical treatment carried out in British psychiatric hospitals. For the most part, it is a case of, "Repeat the mixture as before," with just a few variations. However, it is perhaps informative to compare judgments on the relative values of different forms of treatment coming under this category and to see how we deal respectively with certain common problems.

Obviously there will be differences in various hospitals of Britain as there must be in the United States. Often, probably, one English hospital will utilize therapy more usual in some American hospital than in other hospitals in the United Kingdom, and the converse also no doubt is often true. In this discussion, there will be an attempt to go through the various physical remedies, more or less in chronological order, beginning with some of the general therapeutic measures utilized within the last 20 years or so, but which have not survived in very popular use.

Hydrotherapy appears to have died out completely in England. The writer knows of no hospital now that uses the tepid continuous bath for states of excitement or agitation, though its use lasted in some hospitals until about 10 years ago. Occasionally,

in the physiotherapist's department, one may see a patient being toned up during rehabilitation by cold showers and the like, but this is not strictly a psychiatric remedy. The old prescription of rest in bed, with plenty of good food and adequate purging, that the writer's first superintendent adopted for every new admission, has also gone. He insisted that everyone pretty well have a month of this when first admitted; but now a hospital is rather judged by the small numbers of those it keeps confined to bed.

The feverish hunting for septic foci, and the infliction upon the patient of operation after operation for removal of tonsils, gall bladder, appendix, and so on, have also gone. This practice never was widespread; but in the Birmingham group of hospitals, under a physician who superintended them until after World War II, this practice continued, and it had some influence on hospitals elsewhere. It is, of course, the general practice in all the better hospitals to investigate the patient very thoroughly for any physical disease and consider its possible influence in the causation of the psychiatric illness. Even if a septic gall-bladder, for example, is found, however, there are few who now believe that it is likely to be the main, or even an important, causative factor. Rather, any physical disease is dealt with as would be indicated if no mental illness were present.

Continuous narcosis, too, has become a very rare form of treatment. It is doubtful whether it ever was as popular in Great Britain as the writer understands it to have been in the United States, and this may well be because of the more intensive way it was done in America. During the War when the writer was able to visit one of the American army hospitals, he was impressed by the depth of narcosis that the doctor achieved and maintained. The writer must confess that the very sight of the patient petrified him, as it always seemed as if he were about to breathe his last. It was apparently not as dangerous as it looked, but the writer has never seen it given anywhere in England in such deep form, other than by an American psychiatrist. That is perhaps why British results were never very striking, and continuous narcosis has largely been given up for such illnesses as agitated depression, catatonic excitement or mania. One still uses a very much modified form of it rather infrequently for the severe anxiety neurosis, or the obsessional state with a big depressive element. It is still usual to use barbiturates though "Somnifene" has been largely given

up. Sodium amytal, with its action enhanced by chlorpromazine, is most likely to be used, and the aim is to produce about 18 hours out of 24 of sleep, with drowsiness during the remaining period. As a precursor to some form of psychotherapy, this procedure does seem to be of value, but, as might be expected, using it in the case of a well-developed severe psychosis is just a waste of time.

Insulin coma treatment has lessened considerably everywhere, and in many hospitals it has died out completely. At the Crichton Royal Hospital in Dumfries, for a long time its main stronghold, it was still being used until a short time ago, but for far smaller numbers than formerly. At The Retreat, it has not been officially given up, but the insulin unit has been disbanded. The unit, until two or three years ago, regularly had up to nine women and six men at a time having courses of insulin coma treatment, but the ward is now used as a senile annex and the one or two patients who have insulin coma prescribed have it on the male or female admission ward. That it is retained at all is because it is still believed to be of value in one type of case. The staff never was particularly impressed with the results of treating the typical dyed-in-the-wool hebephrenic, the cases that 20 years ago would have been classical textbook examples of what was called dementia praecox. The results in the paranoid types were distinctly better, but disappointingly short-lived in such a large proportion. The illness it is now used for is the borderline case between simple mania and catatonic excitement of moderate degree. The writer believes British criteria for diagnosing schizophrenia differ from American; and the British perhaps tend to say "mania" when Americans say "schizophrenia" in the type of disorder referred to here. At all events, many of these patients do seem to have remissions fairly quickly after 20 or so fairly light comas. That light coma is another attraction of course. The patient has to be definitely in coma, but not so deeply comatose as seemed necessary to produce results in the paranoid cases. The reason one often uses this method is because it has been found that electric shock therapy in such patients appears almost invariably to produce markedly temporary remissions. Irreversible coma has lost much of its terrors, since hypertonic saline seems a quick answer when it does occur. The Retreat, therefore, still retains insulin coma therapy, but just barely retains it, one might add.

What is called modified insulin treatment or "insulin sopor" is often used, surprisingly often in fact when one reviews the tangible results and finds they are pretty inconspicuous. In general, the writer really feels, it is given mostly so that patient, relatives, and indeed the doctor himself, can feel that some treatment is being given. Sometimes it is prescribed with this sole purpose in the mind of the doctor, that is to counteract the defeatism that can arise when there is no obvious therapy taking place. It may easily act by suggestion on occasion; for example, the woman psychotic who has lived alone and neglected herself to the point of definite malnutrition, will perhaps benefit mentally as well as physically from its use. The writer followed up some cases three years ago, and the recovery rate appeared to be exactly nil. But, as noted, the treatment is still widely used. Combined with a course of electric shock therapy, it still does occasionally appear to stabilize some patients who relapse repeatedly after a course of electric shock therapy alone. It is used fairly regularly, too, for the somewhat rare cases of anorexia nervosa that come to the hospital, but, again, results are not very impressive.

Electric shock therapy, on the other hand, is ever more widely used. In fact, one feels often that it is a pity it produces such dramatic, if so often short-lived, results. It is too easy to give, and nearly always produces an immediate, apparently good, result. What has happened, one fears, is that in many hospitals it is virtually the only treatment used, and the practice has given rise to the epithet "press-button psychiatry" to describe this tendency in many places. In some of the larger state hospitals, overcrowded and under-staffed, this is understandable, if still inexcusable. The standards of staffing in England are very different from American; and this again will give some insight into the reasons for the overpopularity of electric therapy. The writer can cite, for example, a local state mental hospital, of whose management committee the writer is a member. It is a hospital of 1,000 beds, overcrowded at present to contain about 1,150 patients. It has a medical staff of three senior psychiatrists, including the superintendent, two or three doctors of intermediate status, and two trainees to deal with this number. There is an admission rate of about 750 a year. Just in case the doctors find too much time to loaf around, they are expected to provide psychiatrists for about 10 half-day, out-patient sessions in neighboring general hospitals,

one of which is 40 miles away and another 24. This state of affairs is only too common; and as might be expected, therefore it is only too common also for every patient except the senile dement to be subjected to electric shock therapy within a few days of arrival.

In such hospitals, the depressive usually has a course of about seven to eight applications, given twice weekly. The manic has usually rather more, often three times weekly. He seems usually to relapse immediately, and then, as a rule, is allowed another course of a similar number. If immediate relapse occurs again, he is usually moved to a long-term ward and treated by tranquilizers, or is allowed to await spontaneous remission. It is customary in such hospitals to treat schizophrenics with electric shock therapy also, again about three times weekly, and giving perhaps 20 shocks in all.The patient with a severe case of schizophrenia, who is admitted only long after the onset of the disease, may be regressed and be given 50 or more treatments, at the rate of one or two daily. Results are very mediocre but not seemingly entirely nonexistent.

It is now the practice nearly everywhere to give every patient electric convulsive treatment in modified form. In most hospitals, anesthesia is induced by intravenous pentothal, and often "scoline" is the drug used as a relaxant. Others merely give "brevidil" without true anesthesia, but morphia and hyoscine are given previously to allay fear. The Retreat adopted the former technique after a short trial of both methods, when it was found that a fear reaction seemed to develop very quickly and often, if true anesthesia were not induced. So The Retreat now uses the pentothal-scoline technique as its routine method.

There has been some attempt to investigate the comparative efficiency of straight ECT and of electric shock therapy in its modified form. The Retreat is at present carrying out a follow-up check on two batches of cases treated some five to eight years ago, to see if there is a significant difference in the results. The figures are not yet complete, but the earliest indication would imply little important difference. On the other hand, the attempts at the same time to evaluate the results of treatment after long rather than short courses do seem to point to an optimum number of treatments. Some patients, who have remissions quickly after one or two applications, give their notices, and insist on leaving —so giving the investigator the chance of following up a number

of patients, some of whom have had very few applications. Others, for one reason or another, have had very many. Although when over seven or eight treatments are given, there seems to be little difference in the stability of improvement, the relapse rate seems higher under this figure. The writer would add that there are, of course, so many variables that the conclusions must be looked upon as being very tentative, as a really scientific control system was not a practicable possibility in this follow-up.

It is the practice in most hospitals to use electric shock therapy as a maintenance therapy, to keep patients who show temporary benefit from it in such a state as to be able to enjoy the hospital amenities better, or, at worst, to be less difficult and less dangerous nursing problems. Many long-term schizophrenics can in this way be kept surprisingly well. Some, after a time, seem to be able to maintain improvement without the treatment, even after having treatment for a year or more, but at The Retreat it has been found that the proportion of such cases is small. When such maintenance treatment is given, it is often given straight or unmodified, and at The Retreat about two in three maintenance patients on the average still have it straight. The criterion is chiefly the degree to which a patient objects to ECT. If a patient shows unmistakably that he is frightened by straight ECT, and many demented patients definitely are, it is modified at once. Another feature of ECT is the way in which some patients seem to become immune to the treatment after a time, or even get into a kind of electric therapy-drunk state, when they are even worse to deal with than without treatment. The curious point is that they do not all exhibit this peculiarity. At all events, keeping them for some months without treatment seems to restore its efficacy.

One last point should be mentioned before leaving the subject of ECT, its use in the older depressive. It is used at The Retreat for the stuporous catatonic, the manic-depressive and the involutional depressive. In the last type, it is noted that at the later age groups (over 65 or so), a much higher proportion of patients tends to relapse quickly after treatment ends. It is now attempted, therefore, to try to taper off treatment in every case over 60, if it is at all practicable and the patient is co-operative. Such a patient may be given seven treatments in three weeks; then one treatment a week for another three; then perhaps one a fortnight for a further month, after which he returns home but comes back

for a treatment each month for the next three months. The early results seem to justify this procedure.

And now to pass on to surgical procedure. Leucotomy seems to have died out completely in many areas. The writer knows of no hospital that treats anybody but depressives by this method, and even depressives are rarely subjected to the operation now. Most of the hospitals in the Leeds region have given it up entirely; and, at The Retreat, there is so much conservatism and selection in choice of case that there, too, it has been virtually abandoned. The Retreat did only one case last year, and two the year before. This year, none has been carried out so far. Experimenting at The Retreat with a modified cut was most disappointing. Sometimes, there was no benefit, and at other times improvement was very transient. In patients who had the more drastic cut, the personality changes were nearly always thought to be of a pretty serious nature; and, again, these patients often relapsed, though after a longer period than patients with the modified cut.

Topectomy, too, was given up some years ago. There had been comparatively few cases operated upon, but The Retreat did have a Sheffield neurosurgeon treat four or five cases of chronic, aggressive and destructive schizophrenics. Some improvement was noted in all, but, without exception, all relapsed—nearly all of them about one and one-half years after the operation. The physician superintendent of the Sheffield Psychiatric Hospital where a much larger number was operated upon, said his experience had been the same, even to the remission lasting in practically every case only for 18 months. The very few cases of lobectomy, open operation for the removal of a large part of the frontal lobes, were done in relapsed leucotomy patients. No benefit followed the operation, and The Retreat did not continue to practise it.

Just a very brief word should record the honorable demise of malarial therapy for general paresis some years ago. Cases of this illness have become very rare indeed in the United Kingdom. The Retreat gets about two in three years, and obtains rather fair results from intensive penicillin therapy if the disease has not progressed too far.

Recently the promazine group of drugs and reserpine have been widely in vogue in Great Britain. Of the former, chlorpromazine is far and away the most popular, and is very widely used indeed.

The history of its inception is fairly typical of many new treatments adopted in medicine generally. It was hailed as a great discovery and one that would soon oust ECT. There were apparently small, but promising, early results; but when the promise remained unfulfilled, the drugs were on the point of becoming obsolete before they had even been widely introduced. However, their use became canalized along two rather restricted channels. First in out-patient treatment of mild psychoses and neuroses, they are very widely prescribed. They seem to help, whether by suggestion (as some claim) or not, one cannot say. At The Retreat, chlorpromazine is used occasionally in such cases, in dosages of about 150 mg. a day if the illness is fairly mild and inconveniences the patient relatively little, and if there are indications that the attack may be of short duration. Also, it may be used for a patient who may have some very compelling social or business reason for not having a stay in hospital for more decisive treatment at his stage of illness. The writer does not feel it is really curative, as even those helped seem to slip back when the drug is discontinued. It, perhaps, merely makes life more tolerable for this type of patient until spontaneous remission occurs, or there is opportunity to give more radical therapy. It is, too, widely used as an adjuvant to psychotherapy in many state hospitals, a matter touched on in the next section of this discussion. For the in-patient, its use is now mostly restricted to the long-term disturbed schizophrenic. In dosages up to 600 or 800 mg. a day, it is continued for several weeks, after which it is reduced appreciably, usually without ill effect. For a large number, the drug does seem to make for much less disturbed behavior. A number of destructive or aggressive patients become docile and even get to the point of enjoying garden parole. Again, however, complete cessation of the drug seems to precipitate a relapse within a matter of days.

Reserpine has been used more commonly lately for the paranoid schizophrenic and has been tried out widely for all kinds of schizophrenic disturbance. The writer thinks its popularity partly accounts for the speed of the decline in the use of insulin coma treatment. The Retreat's practice is to give it both orally and by intramuscular injection in rapidly increasing dosage until the patients are having 15 mg. or more a day. One keeps it at this dosage for several weeks; and, lately, the parkinsonian effects that are often produced, have been treated by oral administration

of "Disipal" (Dimethyl amino ethyl 2-methyl Benzhydryl ethyl hydrochloride). Enough cases have not really been collected and followed up to assess reserpine's permanent value. One can only say that the early results again have shown some promise. Many paranoid cases, (delusional illnesses occurring in middle age that British psychiatrists tend to distinguish as "paraphrenia" from schizophrenia, a term restricted to cases occurring earlier) have appeared to have remissions in the face of bad prognoses; and it was the writer's strong impression that even deep insulin coma would not have been effective. But the writer knows how misleading impressions can be, and does not labor the point. It is enough to say that immediate results have been seen with reserpine in this type of case, and so use of the drug is continuing, with a follow-up intended in due course. It is a method very much in vogue at present and the experience of most colleagues seems to resemble the writer's. No one seems to be quite as enthusiastic as the results published by Dr. Moore from Dublin, would have led people to hope, but reserpine certainly is being used a good deal. While on this subject, one might make mention of seeing an increase in the number of depressives who have histories of reserpine treatment of hypertension before their hospital admissions. The writer supposes that it is not absolutely safe to blame reserpine; and yet the frequent occurrence of a depressed phase during psychiatric use of this drug would seem some confirmatory evidence. What the writer would comment upon is the intractability of some of these apparently reserpine-produced depressions in hypertensives. They often seem more resistive to treatment by electric shock therapy and other methods than the average case of involutional depression that occurs in about the same age group.

Meprobamate is used a good deal in general practice in the United Kingdom but very little in psychiatry. At The Retreat, and the writer believes, at most other hospitals, it is rarely used at all for the psychotic states, as any beneficial effects worth talking about are most infrequent after its administration. It is sometimes used at The Retreat for the severe phobic and obsessional patient, whom it is felt to benefit, if the patient—because of circumstances beyond anyone's control—cannot be given any effective form of psychotherapy. It is often used, too, in an

attempt to allay fear and apprehension before some other form of treatment (for example, ECT), using 800 or 1,200 mg. orally.

Before dismissing the subject of tranquilizer drug therapy, perhaps one can say comprehensively that the various related medicaments in each of the better-known classes are in use here and there all over the country. Nearly every hospital uses some or several, but, apart from those already discussed here, one would say that the use is experimental. Someone will try out promazine hydrochloride or benzyl promazine, on 50-odd cases, with or without controls, either to publish the results, or for his own interest. In no recent publication in the United Kingdom has any responsible psychiatrist claimed any particularly great virtues for any experimental drugs, certainly not over and above the fairly modest results of the first ones introduced.

And now to another matter which by and large has so far disappointed so many of us, those of us who have felt that research along biochemical lines, and in particular endocrine function, would prove very fruitful. One still feels that a reward of really big moment will one day come to those who have done so much work in this field, but as yet there has been little but disappointment. Since Professor Max Reiss left Britain for the United States, his big biochemical research project in Bristol has virtually folded up. The same thing can almost be said of similar work at St. Ebba's Hospital in London since its mainstay, Dalton Sands, died a few months ago. At The Retreat, there has been work in a much smaller way along the same lines, research into 17B-ketosteroids, but this is temporarily held up through lack of funds, because it is a pretty costly concern for a small private hospital to subsidize. In the way of applied practical treatment following all this, there is little to show. The Retreat and other hospitals are still using dehydroandrosterone, and for one special type of case, results have been claimed elsewhere, though at The Retreat, the figures so far are too small to be conclusive. The type of individual who is held to benefit is the young—not much over 20—immature, schizoid person, whose general inadequacy to face up to the demands of life is deemed the main stress situation that causes a later schizophrenic breakdown. Long-continued oral administration of 60 to 100 mg. per day is usually suggested as a reasonable dosage. It has been used for such patients who have had remissions in schizophrenic illness, remitted with or without

treatment. It is used after the remission, in the hope it will avert recurrence. So far, there is no conclusive evidence in The Retreat's small figures to prove or disprove its worth, and further trial is continuing.

The estrogens in various forms, usually stilbestrol or ethinyl estradial, are used fairly widely, when patients agree, to control the problem of homosexuality. In prisons the use of estrogens was prohibited, the writer believes, after one enterprising person claimed after his discharge, on the authority of some medical pundit, that the use had produced some irreversible testicular atrophy. The writer was informed that he received suitable damages, and as said, the use of estrogens in prison is prohibited at the moment. Few medical men, however, believe that such irreversible atrophy does occur, and in the expected New Act, the dispensing of these hormones to co-operative prisoners will be allowed. Apart from these two preparations, the field is just about empty, as the writer knows of no hospital now which believes menopausal psychiatric illnesses of severe enough character to need hospital care, are benefited by estrogens, or any other known hormones. Many hospitals have tried more or less perseveringly, but few have claimed worth-while results.

To conclude, one can finally touch generally on those ancillary treatments which, although in rather a different category from those previously mentioned, are still physical treatments. Occupational therapy is so much a part of the main hospital therapeutic activity that there is little fresh to report about it. It plays a large part in the work of every hospital, although naturally some consider it more valuable than others and employ more money and time on it. Nowhere is it quite the force it was in the early 30's when in many hospitals it seemed to be the one and only treatment, and hospitals vied with each other in their attempts to raise the percentage of patients occupied up to and above the 93 per cent figure, by the use of the most astounding strategems. This is not now the case, but there are few who doubt occupational therapy's great value, indirect rather than direct, in promoting recovery. There have been certain outgrowths of it, however, that are worthy of mention.

Art therapists, for example, are becoming more numerous, and one is employed at The Retreat. He is a firm believer in the therapeutic efficacy of painting as self-expression. One would like

to see more definite evidence before claiming it as important in this sense, but the writer believes its indirect value is of material proportions. Its diagnostic use is, the writer thinks, more clear-cut, but the two do not go together, and there is little doubt that free self-expression is curbed in nearly everyone to some extent, if he has the knowledge that later a painting or drawing may be looked at and studied as evidence of his mind. Hitherto, therefore, the therapeutic aim has been accepted and, only occasionally, and somewhat by stealth, for some particular reason, has there been study of a painting with the art therapist for diagnosite purposes.

One or two hospitals, likewise, have music therapists, though the writer is happy to say that they work on lines not completely analogous to those of the art therapist. One would dislike intensely working in a hospital where patients were allowed free expression on violins, pianos, mouth organs and the like, without any previous training on the particular instrument used. The Retreat did employ a music therapist for a short experimental period. The activities were mainly directed toward reviving an interest in music in those previously skilled or greatly interested in the subject, in an attempt to obtain single points of contact with otherwise inaccessible patients, and then try to enlarge the contacts. The therapist did this by organized classes, both for groups and individuals. Some classes would be passive, that is would listen to music of various kinds, others would be more active, for example, with community singing, percussion bands, or individual piano playing. This seemed to be an interesting line to develop; but the woman with whom this project was begun left after six months or so, and a really suitable person has not been found since then. Clearly such a venture calls for very definite personality traits in the therapist as well as a good knowledge of psychology and music.

Turning to physiotherapy, many hospitals, although by no means all, now have physiotherapists. Apart from giving the treatment indicated for the physical complaints of the longer hospital residents, the department usually attempts ancillary psychiatric treatment in two ways. First there are the patients whose illnesses have been long and rather debilitating; and sometimes, of course, it is the specific treatment given them that has been debilitating. Daily classes are given for groups of such patients along lines rather more scientific than the ordinary keep-fit class. The other

patients who seem to benefit are the tense, anxious persons. Whatever other treatment such patients have, relaxing exercises are nearly always prescribed. Patients will be seen two or three times a week and taught relaxation; and, if necessary, appropriate massage will be given. In addition, these patients will attend as a group a few times weekly and go through a course of relaxing exercises, many with the aid of appropriate music. As in the case of occupational therapy, it seems impossible to obtain figures to prove the value of treatment of this sort. All one can say is that it does seem to help; and almost invariably the patient himself believes that it is helping. When this is so, one feels that it is likely to be the case.

Recreational activities too have been organized to a much greater extent than was the case even 15 years ago. All the large hospitals run their own patients' football and cricket teams, as well as staff teams, which the patients then support staunchly in their various league features. Bowls is ever-popular, and, of course, tennis with the younger patients. Of them all, the only one the writer ever prescribes as treatment is bowls. It does seem to be able to hold the interest of the elated, restless person better than any of the other games, and to bring about relative tranquility for some time afterward. Finally, the patients' social club should receive a mention. Again, very nearly every psychiatric hospital has its patients' social club, run entirely by patients who elect their own chairman, secretary and treasurer, and organize their own social events. At most hospitals, as at The Retreat, a member of the official staff sits in at the election meetings as a silent observer, one who would intervene only if a completely unsuitable choice, medically speaking, is put forward. Otherwise the patients do as they please and on the whole do it very well.

Discussion of the physical and related therapies brings up the matter of aversion therapy for alcoholism. It is still rather widely used. At The Retreat it is used in nearly every co-operative patient after he has been tided over the acute alcoholic stage by the usual measures of vitamin injections, and intravenous glucose, saline, insulin and sedation, as and when any of these are indicated clinically. The course of apomorphine or aversion therapy takes three to four days. To describe it briefly, the patient stays quietly in his room in bed and every three hours is given a glass of the alcoholic beverage to which he is primarily addicted. At the same

time he is given an injection of apomorphine, 1/10 gr. The latter produces nausea and vomiting. This goes on day and night, and the patient is allowed no other drink than the liquor. Food is not prohibited, but after the first few "drinks" he becomes so dehydrated that he cannot eat a thing. As the course proceeds, it is usually necessary to increase the dose of apomorphine gradually by increments of 1/20 gr.

Undoubtedly, this regimen does, in many cases, produce through the nausea and vomiting a conditioned reflex, making the smell, taste and often the thought of a particular drink objectionable to the patient. As a single measure of treatment, the writer does not rate it very highly; but as one of a number of adjuvant measures that are followed by psychotherapy, help from antabuse and perhaps Alcoholics Anonymous, it seems worth while. It sounds horrid, and people who undergo it confirm one's impression of it, but it seems to be quite without dangerous risk, if begun after the patient is well over the phase of acute alcoholism.

IV. Special Treatment Procedures

In the first section of this paper, there was rather brief reference to the question of psychotherapy in the general psychiatric field, not, of course, because the writer believes the matter to be unimportant, but because its practice in the United Kingdom, and, perhaps also in the United States, is found in so many forms. A full discussion is needed if any explanation is going to succeed in even showing the background, which has altered so much since World War II, and especially since the introduction of state medicine. This discussion will begin with an attempt to outline the salient features.

First, there is a staggering amount of human material now held by the majority of the medical profession to be in need of psychotherapy. Admittedly, this conclusion is often reached because symptoms are manifest principally in a patient's behavior, and because no other medical methods are known to help; but, at any rate, it is a big advance to have the medical profession so nearly unanimous in opinion. Only a dozen or so years ago, the majority of general practitioners and consultants in other specialties than psychiatry paid little attention to the neuroses. Many derided the idea that a neurosis was an illness, and indicated more or less bluntly their belief that the persons concerned were not ill and just

needed pushing around till they pulled themselves together. Having said this, however (and needless to say), they gave up so tiring and unprofitable a task, and passed the patient on to someone else as soon as possible. Even those doctors who agreed that neurosis was a case of illness, usually showed by their conversation and attitude that they had but a poor conception of psychological disease, and no real understanding of the mental mechanisms involved. They seemed to think that the differential diagnosis in any case was between "plain insanity" and malingering, not really appreciating even the concept of unconscious motivation.

A number of studies into the causes of industrial invalidism, notably the one done at the Austin motor works in Birmingham, which was carried out for the most part by industrial medical officers who were not psychiatrists, helped to bring home the problem sharply. At a modest estimate it was said between one-quarter and one-third of all people away sick from work—and at the huge factory the daily sick would run into thousands—were found to be suffering principally from psychoneuroses, although generally the diagnosis on the health certificate from the family doctor was of some vague physical disorder. Better psychiatric teaching of students while going through medical school helped to show the younger general practitioners how true this was. Of a young doctor's perhaps 50-odd patients to see each surgery session, he would find that 15 to 20 were really suffering from no organic disease. The doctor found it was useless to bully these patients or kick them out. They just came back and wasted the doctor's time, for of course it was considered a waste of time; and it probably was, when he had no real knowledge, means or time to give adequate treatment. In addition, such patients would clog the machinery of the various hospitals by going from doctor to doctor, who would send them from specialist to specialist, who would order investigations, x-rays, and so on, one after another. The problem had to be faced. The country could no longer afford to have so much of the population idle and therefore unprofitable; and the state hospitals, already overworked, found that those needing physical treatment had to stay on longer and longer waiting lists, because of the neurotics swelling the numbers at every clinic.

This, then, was the first mass of clinical material. The second element was small in comparison, but important because more

spectacular, the problem of serious delinquency. More and more, the public conscience had been pricked by the realization that returning persistent criminals to prison, time and again, was useless as a corrective and was perhaps being unjust to the offender. When the conscience was not being pricked, public fear was being aroused by the colorful newspaper reporting of the occasional violent hold-up, murder or serious robbery. Prison sentences were not diminishing the problem; so what could those specialists who dealt with abnormal behavior do about what was essentially very abnormal, as well as antisocial, behavior?

Next came the mental hospital population, which was seen to be growing steadily year by year, every hospital overcrowded and with the cry from all regions to build more and more psychiatric hospitals. Could something be done to diminish the number of patients rather than increase the number of beds? The treatments introduced as new in recent years seemed to be able to restore those taken ill more quickly to the outside world than before; but what could be done to make such restorations more permanent? And what could be done anyway to prevent patients getting bad enough to need mental hospital care? These questions were held to show, quite rightly, that there was further need for psychological investigation and treatment.

Watch the children and adolescents showing aberrant behavior, and treat them then so that serious psychiatric breakdowns do not occur. If a breakdown does occur, see, after the remission, if any further preventive treatment can be given to make it the one and only stay in mental hospital ever needed by that particular person. These were the objectives.

Finally, there was the everpresent problem throughout every stratum of society of the psychopaths, more particularly the alcoholics, drug addicts or sex perverts. These were another group of people who, in the eyes of the general public, obviously needed treatment, even if the individual sufferer more often than not, showed little enthusiasm for any such project. The psychopaths added a fourth appreciable element to the large mass of potential case material for psychotherapy; and the total represents a considerable quantity of work for a large number of doctors, as everyone will agree.

The next step is to review the facilities there are for doing this work. Who are the trained personnel and what are the organ-

izations in which they undertake their tasks? First and foremost, are the state hospitals and their staffs. These staffs make up nearly 90 per cent of the number of psychiatrists of all grades from trainee to consultant. The other odd 10 per cent go to make up the relatively few psychiatrists on the university staffs and on the staffs of teaching hospitals, the even fewer who nowadays are doing private psychiatry only, and the rather greater number associated with child guidance clinics. A few psychiatrists are employed in miscellaneous jobs, for example, attached to prisons, or in such special clinics as Tavistock and Portman.

The state hospital psychiatrists are, in overwhelming majority, full-time salaried employees of the state. They spend about three-quarters of their time on the average, working in the hospital on whose staff they serve, and about one-quarter in clinical sessions at nearby nationalized general hospitals, seeing psychiatric out-patients. Most of the population are state patients these days, so they have psychotherapy, if at all, in these clinics. As might be guessed, the demand for treatment greatly exceeds the supply of therapists, which is deficient both in quality and amount. When the state took over, the official grading of the hospitals staffs was made then and there. Dr. X. would perhaps be graded as consultant psychiatrist. Dr. X. might be a most gifted physician among psychotics or mental defectives, but he might have spent literally all his career working among mental defectives or psychotics, for few neurotics ever did and few, even now, ever will enter the portals of a public psychiatric hospital. Yet Dr. X., then and there was expected to go forth and treat neurotics in the local general hospital two or three times a week. This kind of thing often occurred. It is almost too astounding to contemplate, and yet it did happen only too frequently.

The wonder is not that the results were poor, but that there were any good results at all, which, strange to say, there often were. It must be confessed that one sometimes did suspect that the good results were in spite of treatment, not because of it. As the writer already has said, however, the treatment given could hardly be called pure psychotherapy, for the procedure invariably included the prescribing of suitable medicines, sedatives and the like; and the typical form it took will be described later. If a patient is brave enough to enter the psychiatric hospital, or lucky enough to go to one of the very few hospitals

specializing in the treatment of neuroses, such as the Cassell Hospital—and many are called, but few chosen for vacancies in these hospitals—he undoubtedly has more thorough treatment. The staffs of these places are all well-trained, many but not all have undergone training-analysis, and certainly know their jobs. They do have to modify their technique, however, because these hospitals have so great a demand made on their beds, that they usually have to restrict treatment to a maximum of four months. No kind of orthodox analysis is, therefore, possible. A very similar state of affairs exists at the private registered hospitals, such as The Retreat. (Four of these survive, the remaining 10 or so having been taken over by the state.) In such private hospitals, the factor that dominates the duration of treatment is usually financial. The many young neurotics, who generally come to a private hospital where there are more amenities than in a state hospital, seldom find that they can afford to stay for longer than two or three months. Some can indeed, stay longer, but the wealth of the patient seems often to be in inverse ratio to the degree of favorable prognosis. The well-to-do patient, who can afford to stay a year or two if necessary, is usually old enough to have amassed wealth, and is then hardly still flexible enough for psychotherapy. In other words, the chief difficulty is time. One is just forced to envolve a technique that is practicable. However good the results of long analysis might be proved to be (and as yet they have not been so proved to everybody's satisfaction), one would still have to find a shorter, less expensive technique for the purely practical reasons of economy. If every neurotic were to have a psychoanalysis, every doctor in the country would have to become a psychiatrist and a full-time psychiatrist at that.

That, in general, is the position, a situation all will agree to be difficult in the extreme. And now for a few words on the attempts to solve this difficulty. The first modification attempted was to control the technique of psychotherapy, with a fair degree of latitude in individual cases, of course. It was attempted to direct the process rather than to allow the material to emerge as it would, in its own time, as happens when free association and other orthodox psychoanalytic measures are mainly used. One works on the general assumption that influences or strains in early life have sensitized the patient's nervous system, and that the stress, perceived or unperceived in the present, has completed the breakdown.

It is assumed that sometimes the earlier influences are of predominant importance, sometimes the later stress. One works along a provisional rough plan as follows, but the writer would once more stress the point that he is giving only a rough outline of a very variable technique.

It is generally necessary to spend the first session or two explaining to the patient what a neurosis is and how it works, and at any rate getting him to agree at the very least to keep an open mind—even if the conviction that his trouble really is organic is particularly deeply rooted in his mind. Incidentally, British nurses are usually hard to convince that they have neuroses; doctor's wives are even worse; and doctors' wives who used to be nurses are worst of all—almost beyond convincing, in fact.

Next a session or two is usually needed to let a patient talk as much as he likes about his symptoms; and it is impressed on him that this is his one chance to do it, because later sessions will be needed to discuss the causation and this later time cannot be wasted, as it so easily can be, by useless repetition of the same old catalogue of symptoms. Even a confirmed hypochondriac often becomes bored with the subject if he is made to talk only about his symptoms for two whole sessions of three-quarters of an hour in duration.

Thereafter, one goes painstakingly through each decade of the patient's life, with frequent backward glances, for perhaps six or more sessions. Finally one takes the present situation, dividing the patient's existence rather artificially, but for purely practical reasons of convenience, into career or work, sex or marital life, and social or recreational activities. No attempt is made to manipulate a transference situation; and though a mild positive transference is helpful, it is kept in strict limits as far as feasible; because its dissipation can call for too much time, if it develops completely.

By this time in the treatment, it is, more often than not, possible to see the pattern of development of the neurosis and the practical steps that are indicated to rectify the position, if any seem possible. The art lies in conveying to the patient the knowledge of these points, that is letting the patient find the facts out rather than trying to point them out by explanation and strong suggestion. Any amount of subtle and continuous positive suggestion, as to improvement already occurring, is held to be permis-

sible, as well as adjuvants to bring about an improved state of affairs by judicious use of medicines and the ordinary hospital ancillary activities. Free association and dream analysis are used only sparingly, and only when the patient is particularly uncommunicative, or is of rigid mentality. The results of this type of treatment are moderately good, and follow-ups over a few years show that they seem to be as lasting on the average as when the deeper and longer technique was used. It is not claimed to be pure psychotherapy, of course, but it is considered that the first concern as doctors is to help the patient in all ways possible, and not merely try out various treatments.

Hypnosis is used comparatively little in peace-time practice, the writer would say; but the amount varies a good deal from time to time. It becomes a popular vogue for some months and then seems forgotten for a year or two, when it comes to the fore again for a time. There are a few psychiatrists, nearly all in purely private practice, who restrict themselves almost entirely to this type of therapy. The writer has sometimes seen patients after such treatment, others perhaps before and after. They all seem to the writer to benefit only so long as the course continues. This, of course, applies to the average neurosis occurring in peace-time; but it does seem as if patients treated by hypnosis can maintain improvement if periodic visits are paid to the hypnotist, but that attempts by the latter to give effective post-hypnotic suggestion to produce permanent improvement rarely if ever work.

On this general framework which, it should be emphasized again, is very elastic, have been grafted a number of adjuvant appendages. Narcoanalytic sessions under pentothal or more rarely ether, are used fairly frequently, usually if early influences seem to be very important while the patient's power of recall is indifferent. Abreactive sessions are used chiefly for the case one sees so much less commonly in peace than in wartime: the acute hysterical neurosis. The drugs mentioned are usually used. The Retreat tried out the carbon dioxide technique pretty thoroughly but it seemed to have little advantage, if any, over pentothal, which is now usually used for the purpose.

Group therapy is widely used as another modification of psychotherapy, partly again as a timesaver, partly for special use for patients whose disabilities are felt to be likely to respond better to a method encouraging the sense of team effort or group unity. It

was mentioned earlier that this technique is often used as the only psychotherapeutic procedure in some clinics dealing with anti-social psychopaths, alcoholics and addicts—for example, Belmont Hospital and the clinics carried on in prisons, where certain patients often receive group therapy only.

Last, on this subject of modifications of psychotherapy, one comes to the use of d-lysergic acid. The Retreat has used it fairly widely during the last four or five years, and, on the whole, has found it valuable. It does seem often to revitalize a course of treatment that is becoming sterile through lack of material in a rigid patient. He will often be enabled to cast off restraint, recall emotional states if not accurate memories; and, at times in a curious way, he is enabled to gain insight more quickly into the mental mechanisms involved. One has learned "to give it a miss" in patients with frank conversion hysteria, as well as in obviously schizoid persons showing any kind of neurotic symptoms. Obsessional and phobic neurotics, and patients showing depressive anxiety seem suitable, and there has been some success and, the writer believes, never a disaster in patients diagnosed endogenous depression who have failed to respond satisfactorily to physical methods of treatment. If d-lysergic acid is to be used, it is usually used after the routine course of sessions which have enabled the psychiatrist to see the case in fairly clear outline. Starting with a dose of 50 micrograms, this is repeated twice weekly, the dose being raised by 25 or 50 μg. each time to that found optimum, perhaps something between 200 and 300 μg. The patient is seen as much as possible during the first four to five hours after taking the medicine; and a long session to work out any material that has emerged takes place the following day. Often, eight or more sessions are given, and after the first year's experience, the patient was got, wherever possible, to return after discharge from the hospital at gradually lengthening intervals for a session, weekly, fortnightly and then monthly, perhaps for six months or more.

It has been interesting innovation and, as was said, has been found useful. The writer would not, however, class it as being of the first importance as a universal therapeutic agent. It does seem to earn one's gratitude by its ability to bring fairly quick improvement in those notoriously long-drawn-out obsessional and phobic states, that are so resistive to treatment in general. Also, if it is going to prove useless or worse, this indication soon

emerges in the first or second session, and its discontinuance then means that no harm is done. It has its pitfalls. Much that comes out is a mixture of true memory and fantasy; and, although the latter, as one knows, can be a more important factor sometimes than memory, the inability to distinguish can be a nuisance to the doctor and at times a worry to the patient. The one attempt that the writer witnessed to have group therapy with patients under the influence of d-lysergic acid seemed most unwise. The effects of suggestion, counter-suggestion, fantasy, and fantasy by suggestion that one patient had on another, caused a confusion in the minds of everybody, including the therapist, which one doubts has been resolved to this day.

What has been described so far is in the main The Retreat's practice in treating cases of psychoneurosis, but the same, though often somewhat shortened, procedure is usually adopted for patients who have shown remission, after physical treatment, from a psychosis. It has been found necessary and helpful, for it frequently unearths circumstances, unsuspected by the patient or his relatives, that have been inimical to the patient's health and can be removed. And yet his judgment or mental efficiency has been too impaired to discuss it previously. It is another tragedy that, in many of those overworked and understaffed state hospitals, little like this can be done. The physical treatment is given, almost invariably electric shock; the patient improves and is then pushed out to make room for someone else. The writer feels sure that the relapse rate can be lowered, to some extent at least, by a simplified and shortened type of psychological approach of the kind just discussed.

This has been rather a long discussion of this one subject, because it is indeed of most nearly universal application, if not the most spectacular work that goes on. Of equal if not superior importance, however, is the matter of psychotherapy in child guidance clinics, perhaps at the moment the main hope of progress in preventive psychiatry. Every British borough council, except the most backward, has its clinic. In most towns, it is under the direction of the chief education officer of the town, and all its employees except the psychiatrist are paid out of education funds. The psychiatrist is loaned, as it were, from the public health service of the town, although in some areas, owing to the disinclination of doctors to leave the state service, the psychiatrist is a

consultant employed by the regional hospital board and "seconded" to the clinic. At all events the clinic, which naturally varies in size from town to town, is made up of units, each unit consisting of a psychiatrist, an education psychologist and a psychiatric social worker, in addition to the ordinary secretarial staff. Some of the larger cities have one or more play therapists as well. Children in need of help are referred from the school through the school medical officer—himself, of course, a doctor in the town's public health service. Sometimes the child is referred directly from the juvenile magistrates court if there is delinquency involved. In theory, the child's own doctor can refer him; and, if his behavior is only abnormal at home, not at school, this doctor would naturally be the one to do it. In practice the procedure is then so cumbersome that the general practitioner is very conscientious if he bothers to do anything; and even if he does, he may be appalled by the size of the clinic's waiting list. In York, for example, where The Retreat staff took over a year or two ago, when no psychiatrist could be found for a long time to replace one who had retired, there was a waiting time of 15 months. As mentioned earlier, the whole specialty of child psychiatry is very much influenced by the strong Freudian bias of those most eminent in the child psychiatry field. Wherever possible, it is insisted that a child psychiatrist have a deep training analysis himself; but the increase in the number of clinics has been so rapid that this is impossible, and probably less than a third of their psychiatrists have been through such a training process.

The procedure adopted in most clinics follows pretty much of a pattern. Each child is usually seen alone about once a week after the preliminary interview and testing; and he attends the clinic, perhaps a further three times weekly, in a group with two or three others. Sessions take place in the playroom, and analysis of the child's mentality and problems takes place through attempts to interpret the various symbols, themes or fears expressed in the child's play and talk. The play therapist attends the sessions when the psychiatrist cannot be present—he observes, comments and discusses everything later with the psychiatrist. The social worker usually does a good deal of the interviewing and visiting of parents, relatives and friends, and also tries to instill in them any particular lessons thought desirable after discussion with the psychiatrist and psychologist.

A certain amount of altering of the environment of a child is often possible, by enlisting the aid of the town's welfare department or the probation officer. If the home is particularly unsavory, admission to a children's home, run by the borough's children's department, is possible. If treatment in a special residential school for maladjusted children is desired, this can be arranged, though often after a time lag. There are also, of course, hospitals for really gross psychiatric illness occurring in children, and admission is carried out when needed. All this is done at the expense of the taxpayer and ratepayer, and the total cost to the country seems pretty close to colossal. This does not matter in the least, provided results are forthcoming; but, recently, doubts have been expressed on this point. With no drop in the juvenile delinquency rate, with psychiatric illness still on the increase, and crime becoming more frequent and violent, voices are heard to question whether child guidance clinics are doing any good. Some cynics even maintain that they do harm by teaching the future criminal at an early age how to work "the psychiatric racket," and in later life spend those periods of enforced absence from society, following his crimes, in a comfortable hospital, rather than in the less pleasing environment of a prison.

The whole subject was raised at a recent meeting of the Regional Psychiatric Group that includes York—in the following way. About 10 years ago, a professor was appointed at the university who was pre-eminently a child psychiatrist. One of his first actions was to begin a university child psychiatry center. Referrals of cases poured in, and the lists of applicants soon mounted. Most of the children were seen at preliminary interview, diagnosed, and then placed on a waiting list for treatment, as soon as the limited numbers who could be treated immediately had been dealt with. The professor later became ill, and he died recently—a year or two after retirement. The assistant of his successor investigated the situation, and found that a great number of names still remained on the waiting list after five years and more. He decided to follow up and compare those seen five years ago and treated, with those untreated and still on the list after five years. Now he is, in fact, a psychiatrist of the physiogenic school; he tended to overstate his case; and he was easily attacked by those present at the regional group meeting, because he so palpably ignored certain very important factors. For example the more serious

cases had had priority over the less serious, and were more likely, to do worse, treated or untreated. Even so, the result of the inquiry was sufficiently startling to make one uneasy; the untreated children had done so very much better than the treated. It was not one of these percentage affairs, needing a statistician to decide the issue, but was in plain figures for anyone with eyes to read. As was said, the inquiry was not valid, but it has made many of the group realize the absolute necessity of evolving some reliable system of assessing results. If the present child guidance set-up and technique are useless, not only are we wasting far more money than we can afford, but we are wasting time and energy barking up the wrong tree in our search for the cause of psychiatric illness.

Now for the lesser organizations, smaller in scope, which will be enumerated fairly briefly. These are the other places and persons carrying out some form of psychotherapeutic technique in Great Britain at the moment. At the Tavistock Clinic patients can still go and receive a course of orthodox analytical treatment; and a psychiatrist, or a would-be lay analyst, can receive an orthodox training analysis. Owing to the great demand for free treatment, however, a patient's prognosis must be excellent for him to be chosen for treatment; and he may have to wait anything up to five years for his turn. At the Portman Clinic an equally able staff concentrates more on the investigation and treatment of delinquency on psychoanalytic lines. It is rather easier to be chosen for this treatment and one can get it started more quickly. One merely murders someone or commits a fairly important robbery, but one must remember not do both together, or he still will get hanged, because murder with robbery is still a capital offense in the United Kingdom.

There are a number of private psychiatrists in London and the provinces who usually hold part-time appointments in state or teaching hospitals. They usually have little time to carry out actual therapy, but as a rule, they see patients whom they then farm out to satellite analysts, medical or lay. As intimated previously, the cost is prohibitive to most people, and most analysts have to evolve a shortened technique. There are, in certain regions, however, one or two psychiatrists who have begun private clinics with voluntary financial help. They aim to see a patient for a fairly nominal fee; and then patients considered suitable are treated by lay analysts and again pay fairly nominal fees. These establishments are very

few and far between. Further, it can be noted that in many regions psychiatric hospitals have appointed a small number of psychiatrists of consultant status purely for carrying out psychoanalytic treatment on selected in-patients. This must be, and the writer thinks is, looked upon everywhere as an experiment or research project rather than an attempt to supply a need. This is proved by the fact that in the Leeds region, where there are some five million population, and some 10 mental hospitals with a total of over 12,000 beds, there is exactly one psychoanalyst of this kind and, as far as the writer knows, no talk of increasing the number. This, the writer thinks, all goes to show that British psychiatry is still in doubt as to the exact value of psychotherapy of any kind.

Now one final matter, and that involves an aspect delicate to broach, because it is one in which some people are sensitive. That is the question of religion and its relation to psychiatry. Many people in England believe all psychiatrists are atheists. In particular, it is noted that many Roman Catholics eye psychiatry with a very suspicious eye, though the writer would at once like to make the point that there are many exceptions. The Roman Catholic archbishop of Liverpool and provincial for Northern England is, in fact, most enlightened; and at The Retreat, though a Quaker Hospital, he can be claimed as a patron and supporter. It is the fact, however, that a great number of people shun psychiatrists as anti-God. There are a number of psychiatrists in the United Kingdom, who openly declare and take such a stand, though not all avowed Freudians do so.

At The Retreat, psychiatrists are rather between two fires. They get it from some because, being psychiatrists, they are presumed to be atheists, and then from others, because The Retreat is a denominational hospital of the Quaker sect and the psychiatrists are presumed to utilize chiefly some form of faith healing as their chief therapeutic weapon. Now as for the former, The Retreat staff members do not agree to the statement that psychiatry and religion are incompatible. They are, at the moment, as a matter of fact, all professing Christians but there have been Jewish doctors at times, and the appointment of Mohammedan or Buddhist psychiatrists, if they were suitably qualified, would no doubt be considered. The writer is sure, however, that the committee would never consider the appointment of an out-and-out un-

believer, that is one who denied firmly what one might call a supreme purpose behind all life and that the ultimate end of it is good. They would not insist on the dogma of any particular sect being scrupulously followed, let alone their own special beliefs in the Society of Friends. Believing in such a purpose and that the treatment of illness is under such guidance, they can only take such a stand, with which the writer in fact fully agrees.

Probably this is as far as many psychiatrists would go in the expression of religious faith; but there are far more who go much further in their beliefs than there are downright agnostics. From the purely practical point of view in treating patients, however, this does make for a fairly unanimous attitude. A patient's belief, strong or otherwise, is not played upon or assailed. At times, it may be felt to be a support or safeguard. For example a devout Catholic's faith makes him resist an impulse to suicide; and in such instances there may be attempts to strengthen this directly or through the mediation of a priest. The main point, however, is that most British psychiatrists have decided that if they do irretrievably remove a person's religion, they have nothing of commensurate apparent importance to put in its place. During certain phases of psychotherapy, it is easy to remove pretty nearly any belief the patient has; but this is believed to be generally bad practice unless one knows he can put something there instead, and something that must be as strong or stronger as a support.

With regard to faith healing, however, the Quaker Hospital has not developed this at all. As Christians, on the authority of the Bible, its supporters would believe that sufficient faith could cure anything, because it is stated that sufficient faith can move a mountain. At the same time, they believe that the possession of sufficient faith like this is of extreme rarity, and that in practice it is as easy to remove illness of serious nature by faith as it is to remove a mountain. Many "cures" by faith healing may well be of functional nervous disorder. The writer has seen more than one over the course of many years, and most of them lasted. Frankly, however, he feels that such healing is really the vehicle of suggestion. And yet so what? If it works, let it! Unfortunately, it does not seem to be a dispensable commodity. If one prescribes visits to church, it does not often happen that faith or suggestion, whichever it is, produces recovery. In any case, to make religion just a matter of being healthy in one's body and nervous system seems

pretty restrictive. It is either a matter of making religion concern itself with the relative trivialities of illness or making religion a quite unimportant thing, compared with its alleged interest in the purposes of an omnipotent being. The psychiatrist's practice therefore, the writer would say in general, is to work at the side of any religious approach rather than with it.

This problem has been particularly marked lately, because ministers of all religions are concerning themselves more and more with psychological medicine. Whether one approves of this in principle or not, one finds in the United Kingdom that it has come to stay. The general medical profession has no time in which to give psychological treatment. There are an insufficient number of psychiatrists to do it. So the psychiatrists' attitude is that if ministers are to do it (and more and more, is this the case), let them, at any rate, be taught to do it properly. Courses of instruction for hospital chaplains have been given in various hospitals in recent years in one or two places in Britain. It is proposed that courses begin at The Retreat shortly for ministers of all religions, working in their parishes. This is, perhaps, the latest tendency; but, as can be seen, it signifies the psychiatrists' desire that ministers be given the basic principles of a psychological approach and some guidance about what to attempt and what to avoid entirely, rather than a desire on the part of psychiatrists to use religion more in treatment. The course proposed would seem necessary, even if it is only to stop the enthusiastic minister from actually doing harm.

To complete this discussion, the writer hopes that, as some of Britain's postwar difficulties have been rather more acute than America's, British attempts to solve them may merit attention, if only to enable Americans to avoid making the same mistakes. In this small way, the British scene can thus serve as a laboratory.

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THE DYING*

BY DANIEL CAPPON, M.B., M.R.C.P., D.P.M.

"Any man's death diminishes me, because I am involved in mankind; And therefore never send to know for whom the bell tolls; it tolls for thee."[1]

John Donne's lines express the general reason for writing this article. Men of medicine have eschewed public utterances on the dying patient. The surgeon is superstitious. He needs to be optimistic and shut out twinges of professional guilt and worry. He turns away. The physician feels impotent. Though sympathetic, he turns away. The psychiatrist faces often the threat of man turned against himself; but if suicide is carried through, the psychiatrist also looks away, covered in guilt and shame. Even the priest absorbs his keenest feelings in rituals. The relatives and friends are immersed and blinded by grief; the nurses busy; only the poet and the philosopher take a look from afar.

Talcott Parsons wrote, "Death, particularly premature death is one of the most important situations in all societies, demanding complex emotional adjustments on the part of the dying person... and on the part of the survivors. This is so important that in no society is there an absence of both cultural and social structuring of ideas about death..."[2] Eissler said the moments of death are the most important in a man's life.[3]

Our cultural creed is optimism at all costs, its slogans, "Life is for the Living," and "Business as Usual." We embalm the dead, with neo-Egyptian reverence, at exorbitant cost, to pay the price for forgetting. We shift insupportable sorrow and fear, to financial sacrifice and subsequent adulation of the marble mausoleum. Though in bygone days, both pagan and Christian, life was transitory and death rewarding—a state worth contemplating—the attitude of nowadays is not less understandable nor unnatural, for, "Men fear death as children fear to go in the dark and as the natural fear in children is increased with tales, so is the other."[4]

Despite our cultural defenses, or perhaps because of the obliqueness with which we meet this inescapable situation, death remains

*This paper, from the section of psychodynamic research, Department of Psychiatry, University of Toronto, represents work carried out in the wards and the out-patient settings of the Toronto General Hospital, Department of Medicine, under the chairmanship of Professor Ray F. Farquharson.

unapproachable, perplexing, frightening. Only religious faith bridges the Styx, whose source lies in the enigma of mind turned to mere matter and in our wrought-up emotions regarding this great unknown. Thus it is that, as the living avert their eyes, the dying remain little understood, nor helped beyond nursing comforts.

The particular reason for this report is to examine some of "Death's ten thousand several doors"[5] so as to help, at least with wisdom, those making their exit. So they can say, "*La mort ne supprend point, nous (les sages) sommes toujours prêt de partir.*"[6] The particular application of this study would be in the field of communication to and from the dying. When, how, what ought one to say to them, especially about their fatal illnesses? To what should one bend an ear; to what need one pay attention?

The general points regarding communication with the dying which this paper makes are:

1. Men die as they lived, beset by abnormalities of character and mood. Though the prospect of death gives them a psychological opportunity to live a while calmly *beside* life instead of passionately *in* it, the dying forego this advantage. Hence they are at least as hard to approach as they were before.

2. The approach of death is usually overwhelming to the ego. There are no appropriate defenses. There is no appropriate emotion to sustain the experience—hence the dying need more than ever their faulty old defenses for support.

3. The general psychobiological accompaniment to dying is that communications within and without the dying person are gradually shut off. Mercifully, psychic death precedes somatic death. In a sense, the psyche came later and leaves first. Thus rapport is tenuous.

4. What one might call the motivational status in dying, bends toward death. It is as though even the significant experiences of life and its unsolvable problems can finally be left to death for resolution, now that libidinal ties are being broken. This finding is contrary to popular belief.

5. Forebodings of death are more prevalent than one would suppose, and depend upon the individual's state of awareness. They increase with conscious knowledge of a disease affecting the body, they are reinforced by the preconscious knowledge of a

diseased body which occurs in dreams, frequently anticipating demise, and they finally break through if motivation favors death.

These forebodings bring fear and panic in their wake, which are indistinguishable from thanatophobic outbursts. The decision regarding extent and quality of communication must rest with the individual case, but may be helped by these findings.

Case Material

Table 1a. Case Material: Comparative Description

Sample	No. of Pts	Kinds of Patients	Death Status
Group A "Experimental"	19	The dying	Patients experiencing the inevitably near approach of death
Group B "Control"			
1	4	The dead	Patients who died a relatively unexpected death at or after an operation
2	18	The fatally ill	Patients facing a lingering death
3	20	The mitral stenotics (for valvoplasty)	Patients facing possible death
4	20	The average physically ill	Patients with nonfatal somatic illness
5	20	The average mentally ill	Patients with nonfatal psychiatric illness
6	3	The attempted suicides	Patients with near-fatal psychiatric illness, seeking death
7	3	The suicides	Patients who died a death they sought

The case material illustrating organic illness was obtained from a general hospital, incidental to a research project on the relation between fantasy and bodily illness.[7] Nineteen of these patients died in the course of their illnesses (Experimental Group A); four more in connection with their operations (Group B 1). They form the main population studied here. Thus it can be said that one attempted to find out, "In the sleep of those dying what dreams *did* come that made calamity of so long life."[8]

The case material illustrating psychiatric illness was obtained from the writer's own patients.

The "somatic" population sampled belongs to the middle and lower-middle social groupings while the psychiatric population

belongs to the middle and upper-middle, and to a slightly different ethnic-religious grouping. Thus, the bulk of the experimental and control groups approximates more nearly the socio-ethnic-religious dimension of the population at large.

The case material was so arranged as to bring out significant differences between those facing certain and uncertain death, at variable speeds of the process; between these and those ill, yet not facing death; and again between these and those ill in mind; and finally between these and those seeking death.

Though the seven control groups (B) form the background matrix upon which the main clinical conclusions regarding the experimental group (A) are based, not all factors are brought out for visible tabular comparison—save where the occasion demands it.

While the mean ages for the experimental and control groups are considerably lower (by eight and 21 years) than the mean for Ontario, the age span comprises most age groups. The groups'

Table 1b. Case Study Statistics

Kind of Sample	Mean Age	Age Span	M:F Ratio	Mean length of observation and follow-up in weeks
Group A	54.3	18-79	12:7	6.6
Group B 1	46	41-49	4:0	5.5
Group B 2	46.6	23-67	15:3	9.3
Group B 3	39	21-48	8:12	5
Group B 4	47.2	17-70	9:11	3.5
Group B 5	34	24-63	11:9	27
Group B 6	33.3	21-43	0:3	21
Group B 7	42.3	21-43	2:1	14
Mortality in Ontario	62.5	——	1.32:1	——
Population in Ontario	——	——	1.02:1	——

Table 1c. Timing—Speed of Death

Sample	Slowly, 1 year	Relapsing and Lingering, Months	Quickly, Weeks	Suddenly, Days and Hours
Experimental Group A	4	9	6	0
B 1	0	0	0	4
B 7	0	0	0	3

average is brought down by the fact that the study was carried out in a hospital for acute disease, and, therefore, the sample is light on the senile and demented patients dying at home or in institutions.

The male:female ratio shows the general trend of males toward dying in younger age groups.[9] The causes of death are representative of the population at large, in that the leading causes of death in Ontario correspond to those in this series, but whereas in Ontario the proportion is 4 heart disease to 2 cancer, to 1 central nervous, vascular, to 1 other, in the writer's series the leading causes are reversed, being 4 cancer to 2 heart, to 1 central nervous, vascular, to 1 other.[9]

The length of time of study was sufficient (3½ to 9¼ weeks) for those somatically ill, and (14 to 27 weeks) for those psychiatrically ill, for adequate rapport and, hence, significant observations. (Ranges of observation time were 7 to 20 hours, and 20 to 50 hours, respectively.)

Method

The method of study was the simple clinical bedside interview approach. Apart from eliciting an adequate psychosocial history and a mental examination to arrive at a diagnostic formulation, an effort was made invariably to obtain fantasy material at sleep and waking levels of awareness. The material was then arranged for comparisons between groups in the hope that significant factors might emerge.

Results

A review of their psychosocial histories and their psychiatric status on dying suggests that, on the whole, these patients died as they had lived, taking their gross problems to the grave. If anything, their malfunctioning was more revealed than ever on the brink of death.

Only two patients were considered normal in the experimental group (Group A); while in the controls (Group B 1 and B 3), three were considered normal.

Case Example

Fairly typical of this series was Case 1. The patient was a man of 46, a foreman in a steel factory. He had asthma, peptic ulcer, and psycho-

Table 2a. Group A. Case Material: Diagnostic Description, the "Dying"

No. of Pt.	Cause of Death	Psychiatric Status
1	Pulmonary edema, R. heart failure	Depression, psychopath
2	R. heart failure	Suicidal, depression
3	L. heart failure, coronary occlusion	Anxiety state
4	Hepatic coma	Character neurosis
5	Chronic myeloid leukemia	Anxiety depression
6	Stomach carcinoma	Paranoid state Paranoid hostility
7	Lung carcinoma	Schizoid personality
8	Lung carcinoma	Paranoid state
9	Hepatic insufficiency	Paranoid state, alcoholism
10	Subarachnoid hemorrhage	Acute depression
11	Sigmoid colon carcinoma	Demented
12	Carcinomatosis (kidney primary)	Schizoid personality
13	Esophagus carcinoma	"Normal"
14	Aortic aneurysm dissected	"Normal"
15	Acute lymphosarcoma	Hypomania
16	Rectal carcinoma	Paranoid with grandiosity
17	Subarachnoid hemorrhage	Panic state, psychopath
18	Carcinomatosis	Schizoid psychopath
19	R. heart failure	Depression

Table 2b. Group B 1. The Dead

No. of Pt.	Cause of Death	Psychiatric Status
1	Pulmonary edema following mitral valvoplasty	Depression
2	Acute heart failure postoperatively	Toxic confusional state
3	Acute heart failure at operation	Dull, hypomanic
4	Peripheral circulatory failure at operation	Depression

dermatosis; he was illiterate and intellectually inadequate, fearful of his ability to hold his job. He had married, late in life, a woman with an illegitimate child and had never forgiven her for this. He was afraid to have children; hostility played havoc with both his psyche and soma. His greatest attachment had been to his mother; he could not shed a tear on her grave, but had had asthma since her death. The writer suggested returning to her grave to see if he could cry, he returned but could not; three months later he died. The patient denied psychopathology and denied dreaming throughout the contact. He was bitter and suspicious. He wanted an out.

Table 2c. Group B 3. "Mitrals"

No. of Pt.	Psychiatric Status	No. of Pt.	Psychiatric Status
1	Psychopathic personality	11	Organic reaction type, dysphasia
2	Healing traumatic neurosis	12	Psychopathic personality, emotional instability
3	Normal	13	Normal
4	Psychopathic personality	14	Psychosomatic reaction in psychopathic personality
5	Reactive depression	15	Psychosomatic reaction type (paranoid)
6	Anxiety state	16	Paranoid psychopath
7	Psychopathic personality, anti-social (sociopath)	17	Organic reaction type, anxiety depression
8	Dysphemia	18	Dull and backward
9	Inadequate psychopath	19	Normal
10	Sociopath	20	Sociopath

Table 2d. Group B 6. Attempted Suicides

No. of Pt.	Means Employed	Psychiatric Status
1	Barbiturate poisoning attempt	Anxiety depression
2	Barbiturate poisoning attempt	Schizoid psychopath
3	Attempts by cutting wrists, poisoning, etc.	Schizoid psychopath, homosexual

Table 2e. Group B 7. Suicides

No. of Pt.	Cause of Death	Psychiatric Status
4	Hanged himself	Acute anxiety, depression in inadequate psychopath
5	Gassed himself	Acute anxiety, depression in inadequate psychopath
6	Barbiturate poisoning	Depression in schizophrenic

On inspection of these tables, one is struck by the apparent relationship between the schizoid and schizophrenic reaction and cancer on the one hand (see Table 2a, 6 schizoids out of 7 cancer cases) and between anxiety and depression and heart disease on the other hand (Tables 2a and 2b, 6 depressions out of 7 heart cases, and only 2 paranoids out of 20 patients, Table 2c). The writer believes this relationship has been noted by others.

The inference to be drawn from the great prevalence of psychiatric illness among those bodily sick is that humans have deep,

corporate and individual hurts affecting their personality structures and functioning, to a degree where a clinical psychiatrist sees little diagnostic difference between a sample incidentally studied in general hospitals and another seen in his consulting office. The main distinguishing feature, other than the presence of physical disease, is that one group came to him, while he went to the other.

And indeed the main difference between the dying through bodily illness and those seeking death because of sickness in the mind may be epitomized, in saying of the former, "But I did nothing upon myself, and yet I'm my own executioner."[1]

Such observations were confirmed frequently in several studies made over two and one-half years[2] on patients physically ill in general hospitals. In the larger study, of which this paper is a part, more than 200 patients with different somatic diseases were considered. If the observations are given credence, they should lead us to reviewing the meaning of our psychiatric diagnoses. It may well be that all illness is a unitary reaction, minor or major, to psychosomatic strains constituting minor or major stress upon the organism.

From the viewpoint of this paper the prevalence of psychiatric illness in the dying suggests that if communication with them is to be meaningful, there is need for skilled assessment of their psychiatric status, followed by handling based on this insight.

Table 3 (3a-3c) summarizes the psychodynamic findings in the dying. While these are based on the intuitive-perception qualities of the observer, they have the advantage of standardization of terminology for a comparative description of cases.

I. *Emotional Status*

Contrary to popular belief, people neither live nor die with hope eternal. Those (four) who showed variants of hope did this by dint of denial, withdrawal or repression. This was the mental maneuver of the meek and mild.

The fear of death, allegedly the heritage of mankind despite the "colossal Christian paradox" denying it, was manifest in but a few (three). It was qualitatively indistinguishable from thanatophobia, because death is not represented in the unconscious; it can only be conceived as a fantasy. Man cannot soberly grasp the real, if mysterious, change to inert matter. His diffuse fear

Table 3. Key to Psychodynamic Description, Tables 3a, 3b, and 3c

I. *Emotional Status**	= prevalent feelings experienced and communicated to the observer.
II. *Ego Status*	= description in structural terms of the "core" of personality.
(1) Unchanged	= an estimate of ego preservation despite the *physical process* of dying.
(2) Dissolving	= ego swamping by *physical process*, with diminishing levels of consciousness.
(3) Weakening	= ego lowering of threshold of vulnerability and regression, effected by *psychological processes* in dying.
(4) Contracting	= ego shrinking by *psychophysical process*.
(5) Expanding	= ego swelling by *psychophysical process*.
III. *Ego Defenses*	= both conscious and unconscious, inner and acted-out, mechanics of ego defense against dying.
IV. *Motivation in Dying*	= conscious and unconscious psychodynamic factors coinciding with or favoring the physical process of dying.
(1) Not to live	= passive hope of escaping life.
(2) To die	= actively seeking death as a solution.
(3) To kill self	= actively seeking death as a revenge.
(4) Not to die	= denying the manifest process of dying.
V. *Foreboding*	= anticipation of death, verbalized prescience.
VI. *Communication*	
(a) To	= patient's capacity and willingness to receive and accept important communications.
(b) From	= patient's capacity and willingness to give out important communications.
(1) Passive	= patient's type of response to another person's telling and asking.
(2) Active	= patient's seeking another person to tell, or who will ask him.
(3) Partial	= sometimes, or about some things, active and passive.
(4) Ambivalent	= patient's type of response in communication, showing willingness and opposition simultaneously.

*The numerals refer to the column headings in tables 3a, 3b and 3c.

is clothed in more or less systematized myth, ideas of an afterlife or nothingness. There is no experiential basis for understanding death, except Lazarus', and more vaguely Dante's, and Orpheus'. There is only the experience of broken love ties for those bereaved.

Hostility ran rampant (eight). Contrary to idealized belief, men die with the gall of bitter hatred in their mouths. Even the cheerfulness considered normal was inappropriate in the face of death. However, it did make communication easier up to the point at which its precarious balance was upset. The fact is that there is

Table 3a—Group A. Psychodynamic Description, The "Dying"

Case No.	I Emotional Status	II Ego Status	III Ego Defenses	IV Motivation in Dying	V Foreboding	VI Communication (a) To	VI Communication (b) From
1	Repressed hostility	Weakening	Projection and denial	Not to live	Not known	Partial; Passive Ambivalent	Partial; Passive
2	Repressed hostility	Expanding	Overcompensatory; belated confession, sublimation to religious conversion	To kill self; punish self and others	None verbalized, implied	Maximal; Active (end only); minimal before	Partial; Uncertain
3	Repressed deviant sexuality; guilt, fear	Weakening	Introjection Early confession	Not to die	Denied	Maximal; Active till near end	Partial; Ambivalent
4	Appears resigned but ambivalently hopeful	Dissolving	Regression	Not to die	Verbalized prescience; certainty	Diminishing to minimal; Passive	Diminishing to none at all
5	Alternately hopeful, hopeless, helpless	Dissolving	Regression	Not to live	Verbalized prescience; certainty	Partial; Passive	Diminishing to none
6	Hostility and fear	Weakening	Total denial	Not to live	Denied	Not at all	Not at all
7	Apparent serenity, inner fearfulness	Weakening	Rationalizing	Not to die	Denied	Not at all	Not at all
8	General hostility	Weakening	Projection	To die; punish self and others	Denied	Not at all	Not at all
9	General hostility	Contracting	Total denial; projection	To die; punish self and others	Denied	Not at all	Not at all
10	Hopelessness	Unchanged	None	To die	Verbalized prescience; certainty	Maximal; Passive	Partial; Active
11	Blind hope	Weakening	Total denial	Not to die	Denied	Not at all	Not at all
12	Blind hope	Contracting	Withdrawal	Not to die	Not known	Not at all	Not at all

Table 3a—Group A. Psychodynamic Description, The "Dying"—Concluded

Case No.	I Emotional Status	II Ego Status	III Ego Defenses	IV Motivation in Dying	V Foreboding	VI Communication (a) To	VI Communication (b) From
13	Normal cheerfulness	Unchanged; effective	Rationalizing	Not to die	Verbalized prescience; certainty	Maximal; Active	Partial; Active
14	Normal cheerfulness	Unchanged; effective	Rationalizing	Not to die; but not to live	Denied	Maximal; Active	Partial; Active
15	Elation	Expanding	Overcompensation	Not to live	Denied	Partial; Active	Diminishing to none; Active
16	General hostility	Expanding	Grandiose	Not to live	Denied	Minimal; Ambivalent	Partial; Ambivalent
17	General hostility	Contracting	Regression; projection	To die; punish self and others	Verbalized prescience; certainty	Partial; Ambivalent	Partial; Active
18	General hostility	Contracting	Withdrawal	To die; punish self and others	Not known	Not at all	Not at all
19	Hopeless, helpless Resentment, despair	Dissolving	Projection	Not to live	Not known	Not at all	Not at all

Table 3b—Group B 1. Psychodynamic Description, the "Dead"

Case No.	I Emotional Status	II Ego Status	III Ego Defenses	IV Motivation in Dying	V Foreboding	VI Communication (a) To	VI Communication (b) From
1	Marked apprehension; depression	Weakening	Mild rationalizing and regression	Not to die	Verbalized report of others;	Partial; Active	Maximal; Active
2	Marked apprehension; negativism	Dissolving	Regression	Not to die	Not known	Partial; Passive	Minimal
3	Excitement; aggression; active hope	Expanding	Rationalizing	To live; Not to die	None	Partial; Active	Partial; Active
4	Hopeless; helpless	Weakening	None	Not to live	Not known	Minimal; Passive	Not at all

Table 3c—Groups B 6 and B 7. Psychodynamic Description, the "Attempted Suicides" and the "Successful Suicides"

Case No.	I Emotional Status	II Ego Status	III Ego Defenses	IV Motivation in Dying	V Foreboding	VI Communication (a) To	VI Communication (b) From
Group B 6							
1	Agitation	Vulnerable; Weakening	Introjection	To die; Not to live	Coinciding with desire	Partial; Passive	Minimal, Passive
2	Resigned, hopeless, helpless	Vulnerable; Weakening	Rationalization	To die; Not to live	Not known	Partial; Passive	Minimal, Passive
3	Hopeless, helpless	Vulnerable; Weakening	Rationalization	To die; Not to live	Not known	Maximal; Active	Maximal, Passive
Group B 7							
4	Panic	Vulnerable; Weakening	Regression	To die; Not to live	Coinciding with desire	Minimal; Passive	Minimal, Passive
5	Agitation	Vulnerable; Weakening	Regression	To die; punish self and others	Coinciding with desire	Minimal; Passive at first; none at end	Diminishing to none at all; Passive
6	Panic	Weakening; Vulnerable	Regression	To die; Not to live	Not known	Minimal; Passive at first; none at end	Diminishing to none at all

no "reasonable emotion" to guide one to the nether world, consequently the habitual mood is trailed there.

II. *Ego Structure*

The ego structure can only be maintained in the absence of cerebrovascular lesions and of toxic, dementing, anoxic and stupor states. By and large, as Somerset Maugham described this in *Mrs. Craddock*, "The prospect of death would be unendurable if one did not know that the enfeebled body brought a like enfeeblement of spirit, dissolving the ties of the world. When the traveller must leave the hotel with the double gate, the wine he loved has lost its savour and the bread turned bitter in the mouth."

It was remarkable to see compensatory ego expansiveness and corresponding elation transcend the dying moments (one patient in Group A and one in Group B 1). It was as good a way as any to make the exit. If natural dynamics do not aid thus a person's demise, pharmacodynamic aids may be considered.

III. *Ego Defenses*

The ego, a pauper in defenses at the best of times, was quite baffled by the darkening specter. Denial was the subterfuge of the meek and mild, hoping against hope, eking out their bleak anomic lives in whose penultimate phases they had already lost the little reason they had for living. Yet they could not look beyond their flickering spirits to stare at the shadow beyond. They spent their last days unthinking, as in most of their lives, and drifted into death with eyes averted, concerned with the immediate, and therefore bodily, minutiae. Despite the pain they wished to escape, they appeared to hang on to life, as Sir Thomas Brown put it, "Labouring against their own cure, for death is the cure of all diseases." Rationalization seemed the only feasible defense. Yet those wishing to expedite their own deaths (Groups B 6 and B 7) also used this means to apparently differing purpose, but with the same ending.

Man being the only animal that prays and reasons, though he cannot conceive of death but only of not living, will use whatever reasoning he may, to attempt to bridge the hiatus to death, and then will pray for the rest. This is what the "normals" did, and to the extent to which they were capable of so doing, limited communication was effective.

Clearly introverted orientation and set of values is the preferable state of ego affairs at the point of death. Hence introversion is one of the psychological desiderata past critical middle age whence death may spread its wings.

IV. *Motivation in Dying*

Motivation in dying was the most curious if not dramatic discovery. Despite extensive maneuvers, even blatant denials, the majority of the patients studied (13) wanted, passively or actively, to die, or at least not to live. In some (two), this wish was an obvious endeavor, demonstrated by suicidal attempts between attacks of pulmonary edema, or by loud protestations that it was time to join the dear dead loved ones.

Generally at first, this realization was culled from between the lines, from oblique references and innuendos, and from trickles of fantasies. Next, a simple narration of a desolate life, with no one else in it, no love, no pet, no interest, and often no possession, suggested that there was nothing but the dregs of libido between survival and vanishing.

Finally, the more direct statement would be made spontaneously. The loose love-ties holding life together dissolved, there remained but the narcissistic investment in the body-self. Now smitten by disease, this tie breaks, and nothing remains. Clearly the popular belief that even dying people want to live is based on the wish of those living vigorously that the dying should do so. The gamut of suicidal motivations, to kill the self, to die with spite, to escape, was demonstrable in Group A even more strikingly and violently than in the group of suicides (Group B 7), the majority of whom were quiet absconders. It is to be noted that those who died unexpectedly (Group B 1) were more inclined to want to live, only one wished not to live. Thus one might surmise that when facing inevitable death, albeit consciously denied, mental energy ebbs, the goal changing equally inevitably. Negative or even destructive trends are revealed more than ever.

Once again, what can the "healthy" motivational status be in the face of this ultimate reality, and with a body often racked with pain? No single patient in the A series really wished to live. The normals did not particularly wish to die, but one of them wished not to live either. There can be no solution to this quandary —only an ambivalent teeter-totter. It is in the context of the

delicate balance of this flux of motivation, that the patient should be told what he really wishes to hear, to stop the pangs of too outrageous an ambivalence. Thus the doctor can do the most good (the least harm) in the circumstances.

V. *Foreboding*

Foreboding (six patients in Group A and one in Group B 1) is really a phenomenon, mostly nonverbal, of communication. In this case, forebodings are foraged out of the whisperings at the bedside—often unduly loud and obnoxious—out of the perusal of the case notes, the conscious contemplation of the body, the obvious experience of chronicity and lack of relief, the preconscious perception of body dysfunction occurring in dreams (when the mind is tuned in to the body) and to the summatory lysis of intuitive dreams. The stronger forebodings are, the more likely they are to coincide with a positive motivation toward dying. The more primitive and hence intuitive person, say a European peasant, the more hysterical or paranoid the schizophrenic, that is, dissociative and grandiose, the more likely are strong forebodings. Yet if they strike the normal civilized man with magical force, his conscious defenses tremble at this inner, outwardly-projected assault. Depending much on the equanimity with which the patient regards this event, which in turn is determined culturally no less than individually, meaningful communication may be made.

To those who have used forebodings as a transcendent symbol with quasi-religious significance to make peace with death, the physician may say that indeed death is near. For the rest, who still tremble and clearly wish to stop their ears to such prescience, reassurance regarding the illusory nature of forebodings must be given.

VI. *Communication*

The lateral viewing of Table 3 shows how to-and-fro communication relates to the mental picture in dying. It is maximal and active where the ego is relatively intact, the mood is cheery and brave, the defense rationalization, the motivation not to die, and forebodings are denied; in other words, this is so where normal defenses cope, despite this enormously abnormal state of affairs.

While on second thought, communication and assessment of intrapsychic functioning in another are, *a priori,* not necessarily strictly interdependent, since ego-swamping can be inferred from

Table 4a. All Samples Demonstrating the Progressive Break in Communication Using the Dream-Report Parameter

Group or Subgroup	Total dreams by each group of patients	No. of dreams per patient per week × 100
A. The Dying	5	4
B2. The Fatally Ill	46+	28
B3. The Mitral Stenotics for Valvoplasty	31	44
B4. The Average Physically Ill	97	138
B5. The Average Mentally Ill	380	71
B6. The Attempted Suicides	40+	63
B7. The Suicides	20+	48

Table 4b. Distribution of Dream Totals

	Total Patients with no dreams at all	Total Patients with one dream	Total Patients with less than 5, more than 1	Total Patients with more than 5 dreams
A.	14	4	0	0
B2.	8	3	2	5
B2.	9	4	5	2
B4.	1	1	7	10
B5.	0	1	5	13
B6.	2	0	0	1
B7.	0	0	1	2

a physical diagnosis without communicating verbally with the patient—and vice versa, since maximal (maniacal) communication can imply ego malfunction—the relationship is found empirically to be as close as common sense, on first thought, would have suspected.

The highlight of the study of communication with and from the dying is provided by the method that uses the reported dream during sleep as an index of intrapsychic and extrapsychic communication. The groups of controls are matched as far as possible with the experimental group, and then equated for differences of number of patients and time span of dream collection in the different groups. Column 2 of Table 4a speaks numerically for itself. Given that one's method of dream sample collection was uniform and that the dream may be justifiably utilized in this manner, it will be seen that there is a gradual shutting off of dreams and

hence of communication, and vice versa, as one proceeds from patients who are somatically and psychologically relatively healthy to the unhealthy and thence to those with fatal disease and thence to those dead or dying either at their own hands, or where the contrast is most obvious to those dying at the hands of fate.

One cannot say, of course, at what point in the process of dying the experience of dreaming is blanketed, at least on awaking. Very likely, in impending dissolution, somatic perceptions in dreams, and dream lysis are experienced long after the reporting of dreams ceases. Then, one imagines, there comes a point, where the morphology of dreams begins to reflect the disorganization that exists in the organism. Likely this is the beginning of the end of psychic existence.

Table 5. Key to Entries under Correlation Between Religion, Medical and Psychiatric Communication, Tables 5a and 5b

Communication To	Religion	= Patient's interest in and acquiescence in own religion
	Diagnosis and Prognosis	= Patient's interest in and acceptance of his illness, its cause and prognosis
Communication From	Social and Medical History	= Co-operation in spontaneous and elicited medical and social history
	Psychiatric History	= Co-operation in spontaneous and elicited psychiatric history and examination
	Fantasy	= Experience and reproduction of dreams, day fantasies and graphic recording (on request) of imagined cause and locus of illness

Passive = not sought out
Active = sought, demanded

Maximum, Average, Mimimum = amount of co-operation and material given

Religion: P.=Protestant. U.C.=United Church of Canada. Angl.=Anglican. Luth.=Lutheran. R.C.=Roman Catholic. Presbyt.=Presbyterian. Epis.=Protestant Episcopal. Gr.O.=Greek Orthodox. Gr.C.=Greek Catholic (Uniate).

Table 5a—Group A. Demonstrating the Correlation Between Religion, Medical and Psychiatric Communications

Case No.	Communication To: Acceptance of Religion	Acceptance of fatal diagnosis & prognosis	Medical history	From: Social & psychiatric history & examination	Fantasy, conscious & unconscious
1.	P.—Angl. Passive	Passive	Maximum	Minimum	Denied
2.	P.—U.C. Active	Active	Maximum	Maximum	Average
3.	P.—Luth. Passive	Active	Maximum	Maximum	Minimum
4.	P.—Luth. No time	Active	Maximum; limited by time	No time	Average; Minimum
5.	R.C. Passive	Active	Maximum	Minimum	Denied
6.	P.—Luth. Passive	Passive	Average; Minimum	None	Denied
7.	P.—Angl. Passive	Passive	Average; Minimum	Minimum	Denied
8.	P.—Luth. Passive	Passive	Average; Minimum	Minimum	Denied
9.	P.—Presbyt. Passive	Passive	Average; Minimum	None	Denied
10.	P.—U.C. Passive	Active	Maximum	Average	Average
11.	P.—Presbyt. Passive	Passive	Average; Minimum	Minimum	Denied
12.	P.—Presbyt. Passive	Passive	Average; Minimum	None	Denied
13.	P.—U.C. Passive	Passive	Maximum	Maximum	Denied
14.	G.O. Passive	Passive	Average; Minimum	Maximum	Average
15.	P.—Angl. Active	Active	Maximum	Average	Denied
16.	P.—Angl. Passive	Passive	Average; Minimum	Average; Minimum	Denied
17	P.—U.C. No time	Passive	Average; Minimum	Average; Minimum	Average; Minimum
18.	P.—Epis. Refused	Passive	Minimum	None	Denied
19.	P.—U.C. Passive	Passive	Average; Minimum	Minimum	Denied

Table 5b—Group B 1. Demonstrating the Correlation Between Religion, Medical and Psychiatric Communications

		Communication To		From	
Case No.	Acceptance of Religion	Acceptance of fatal diagnosis & prognosis	Medical history	Social & psychiatric history & examination	Fantasy conscious & unconscious
1.	P.—U.C. Passive	Passive	Maximum	Maximum	Maximum
2.	Gr. O. Passive	Passive	Average	Average	Minimum
3.	P.—U.C. Rejecting	Active	Average	Average	Average
4.	Gr. C. Passive	Passive	Maximum	Average; Minimum	Average; Minimum

Finally if one takes as indices of accepted communications the ministrations of religion and the acceptance of a medical diagnosis and prognosis, and as indices of sharing of communication, co-operation in giving a medical and psychosocial history, submitting to a mental examination, and finally reporting fantasies of waking, dozing and sleep, one can see at once that the patient is prepared to receive to the extent to which he gives. The finest index of giving is the sharing of dreams; the most stable index of receiving is the seeking for religious rites and confirmation of faith. Truly one might say, "The Priest and Doctor we alike adore when on the brink of danger, not before. . ."[10]

Discussion

Though this paper makes no claim to add to thanatology, because it is dedicated to pragmatism, one can hardly escape metaphysical implications in dealing with a subject of this nature. Certainly, analysis of the lives of these patients who were dying bodily, and analysis of their motivational status, has analogues in those dying so many different kinds of death: the nihilism of depression, the fragmentation of schizophrenia, the psychopathic bid for the electric chair, the heroics of the soldier who wins the VC, the drowning in toxic drugs and alcohol, the daring of death riders on the water, land or air. It is even manifest in those who destroy promising careers by their compulsions of "being late" for everything important. One is tempted to go along with Eissler,[3]

Bergler,[11] and Freud,[12] who postulate the concept of mortido, or a self-destructive unconscious force. One feels that, but for the mysterious *elan vital* of Bergson, the Eros of Freud or the Libido of Jung[13]—but for its last ditch cathexis in the body ego, but for the fear of yielding the psychic ego to the great unknown—the threads of life would be cut sooner rather than later by most men, in abandonment to mortido. Those threads would be cut, depending on opportunity and inclination; abandonment to potentially killing disease; abandonment to psychic annihilation; or the active seeking of the sundry forms of bare bodkin that might quietus make. It has been said that from the moment of birth, life is a struggle with death. It is entirely likely that, since man is a psychosomatic construct, the death processes of catabolism should be hitched to mortido, clashing with anabolic libido, in phases, until the end when death stands triumphant. Thus the energy of life emanates from the opposition of those two great forces, personified by Eros and Thanatos. Here it may be useful to distinguish between mortido (opposed to libido) subserving natural catabolic processes, and the perversion of libido, of all life instincts, and their manifestation in positive destructive (death) drives, supported by murderous hostility. While mortido is a theoretical construct, never manifest, always presumed in the actuality of normal existence and non-existence, the destructive (death) drives are pathological phenomena, abundantly manifested clinically. Certainly the conscious fear of death, in the dying, as in the neurotic, has roots in this destructive death drive —since it is an ego defense against the wish to die, binding the self to the person's (the Id's) deep wishes. This pathological perversion of life instincts, turned to destruction, is given impetus by the social structure of a person's life, by its tragic events; and is given coloring by the specifics of personality. When it reaches its climax in dying and in death, there is an ultimate fusion in mortido—a fusion with all that has to perish and decay.

As for the practical matter of communication with and from the dying, the main points made in the beginning may be reiterated. These findings suggest that there is no personality change in the period of dying. Only one patient of this series made a religious and characterological conversion—stimulated by the fortuitous contact with this author, who was prying into his soul.

Case Report

Case 2 is that of a man of 61 who was in the radio and electronic business. He had had hypertension, incidents of myocardial infarction, and left heart failure, and had been hospitalized on and off for a year. Actively suicidal, he needed special nurses to prevent him from throwing himself out of the window. After these suicide attempts he would go into pulmonary edema, then rally round, only to repeat the cycle. He said it was taking him too long to die. Unwanted, bitter, suspicious, he wanted to punish those who had hurt him.

He was the eldest of eight children. As a child he was beaten cruelly, "for nothing," with baseball bats and such things. His hatred of father and brother was intense and lifelong. He had had "only one friend in the world," who died just before the patient's recent illness began. The patient said he had lived wildly, "strewing the farmlands with illegitimate children." His wife bore him no children, was no companion. Death was a friend; he envied patients looking less ill than he, arriving after him, and released to die before him.

After these confessions, his long-lost ex-alcoholic brother came to his bedside with a Bible; his sister came 5,000 miles; his family and friends gathered. For the first time in his life, he felt wanted. He turned to evangelical beliefs, and became peaceful; suicidal thoughts ceased. He realized it was too late for recovery ("Anyway if I lived I could not pay the hospital bill"); and though he rallied and even planned a new life on discharge, he sank into hopelessness when he saw his body would no longer follow his wishes. He died, without ever having divulged his dreams.

To determine to what one should bend an ear, and to what one should give tongue, the patient's psychiatric status, his prevalent feeling tone, his ego status and the state and quality of ego defenses, his motivation in dying and his forebodings should be reviewed. Most particularly a seemingly casual attempt should be made to sample his fantasy, and his religious inclination should be observed. The gestalt obtained from this information should guide the physician, who must rely on his good sense and intuition in each individual case, when he makes meaningful contact with the patient.

In the writer's opinion, it is *never* justified to tell a patient a fact about his dying that the doctor perceives from an adequate study, that he truly does not want to know consciously, even to

bear. Even if such neglect leads to hardship on those left behind, it is not justifiable to disturb the tenuous balance of the dying, whom one cannot help, for the sake of the living who may help themselves.

On the other hand, it is not warranted to withhold information from patients in whom adequate study reveals the need to know and to be treated as "normal" adults. One must remember that even the reality of a fatal prognosis can be a relief from the agonizing ambivalence and struggle with the question of whether to know, whether one has to face the great unknown. Sometimes such confirmation can bring even secret gladness and release. And yet one must be cautious in this kind of frankness, for, as could be seen from the study, an apparent serenity and desire to be told, does not always coincide with the real feeling. One cannot rely, as in other instances, on the dourness or the pliability of adequate defenses—except on the purposeful blockage in taking in communication, which, as mentioned, should never be violated.

In the last instance, one must watch the approach of the clergyman, treading lightly on the shadow of the patient's death. He will be received according to the flickering flame of libido still integrating the ego, according to the motivation in dying and according to the nature of defense against the final event of death. One may mend the damage if the clergyman is waved away by the frightened patient, or one may consolidate his strengthening ministration with one's own brand of kindly, earthly, human ministration and truths.

Probably the relevance of this paper does not consist so much in its findings as in the fact that only rarely will one of us men of medicine turn to this subject for a scientific appraisal of its varied, frightening and likely unfathomable implications.

Summary

A psychodynamic study of the dying was made incidental to a larger project of researching on the relationship between bodily illness and fantasy.[14] The study, carried out in the wards of a general hospital, included 19 patients who constituted the experimental group and 88 patients divided into seven control groups for purposes of comparison.

The study of the psychology of those dying patients was focused on developing an understanding of the process and aimed for the emergence of criteria on which to base meaningful communication with the dying.

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AUTOEROTIC AND HOMOEROTIC MANIFESTATIONS IN HOSPITALIZED MALE POSTLOBOMY PATIENTS*

BY MOSES ZLOTLOW, M.D., AND ALBERT E. PAGANINI, M.D.

This report covers the sexual manifestations of 100 unselected cases of male postlobotomy patients, all of whom have been institutionalized for at least 10 years.

The original impression of the authors was that for about two or three years following lobotomy, no problems in management, due to aggressiveness, were observed; but that following this period, management problems arose because of the sexual behavior of the patients. It was also an original impression that, because of the situational factors, or because of the lobotomy itself, there was a release of sexual inhibitions, producing such behavior on the wards as to constitute a minor management problem in most cases and a major one in a few.

A review of the literature shows that Freeman and Watts[1] state, "Sexual behavior in a majority of cases does not seem to undergo any great alteration." McKenzie and Proctor,[2] in a study reported in 1946, state that there is "increased sexuality in some 25% of these cases with a return to normal in 18 months." The latter authors also report, "It would seem that the post-operative inertia manifested by some patients reduces the tendency of the individual to seek sexual gratification. On the other hand, the suppression of the restraining forces may lead to a freer expression of personality along sexual lines." Hutton[3] reported in 1947 that, "No sexual excesses or increase in vice occurred after lobotomy." In April 1951, Levine and Albert,[4] in an excellent study of the sexual behavior of 40 nonhospitalized postlobotomy cases reported, "Because of the inability to assess the importance of such factors as long illness and hospitalization, long periods of enforced abstinence, aging, and changes in attitude of potential recipients of love and affection, we consider it well nigh impossible to draw any sweeping conclusions as to the effect of lobotomy on the sex life of a psychotic individual."

Summarizing the available literature on the subject left the authors with some obvious confusion and a desire to study the problem more closely.

*The work reported in this paper was done at Pilgrim State Hospital. Dr. Zlotlow is at present on the staff of Middletown (N.Y.) State Hospital.

One hundred postlobotomy patients, well known to the authors, from the male continued treatment buildings at Pilgrim (N. Y.) State Hospital were taken at random for study. It was decided that observable masturbation, observable *coitus in ano*, active or passive, observable active or passive fellatio, observable kissing, fondling and caressing would, *ipso facto*, be held to constitute autoerotic and homoerotic manifestations. Since all the patients are hospitalized, it is natural that attendants' ward notes should constitute the major source of most of the information in this respect.

All patients in the study were diagnosed as having schizophrenic reactions, except for three mental defectives and one epileptic. Most of them were hospitalized at least five years before lobotomy was performed. Most of them were lobotomized at least five years ago; and all except two were lobotomized at Pilgrim State Hospital by a single neurosurgeon, using a single classical technique. All were lobotomized because they constituted severe management problems; they were assaultive, restless, aggressive and destructive. Only 10 of these patients had been considered well enough for release on convalescent status, and all of these were returned in less than a year. Twenty-eight patients still remain aggressive and assaultive, requiring periodic restraints, camisoles, isolation or ataractic drugs.

Sixty of the 100 patients show homoerotic or autoerotic manifestations at present. Of these, 40 had previously shown the same manifestations before operation, thereby leaving 20 who apparently developed them after lobotomy. It must be noted here that the preoperative manifestations were revealed by both anamnestic data from relatives and/or physicians' and attendants' notes and observations. It is obvious, therefore, that in many instances, the sexual behavior of the patient was not reported. An attendant who has been working in the same building for approximately 20 years, and who knew these patients before, as well as after, operation, remarks: "We were more worried about their assaultiveness and did not pay much attention to their sexual behavior. Besides, so many of them were in camisole and restraints. Today the patients are more quiet and the sexual perversions come more to our attention."

Continuing the analysis of the figures, eight patients had homoerotic and autoerotic manifestations before operation, which dis-

appeared following operation. Finally, 32 patients had no manifestations before the operation and have had none to date.

Representative Case Reports

E. R. (Homosexual before operation; no homosexuality immediately postoperatively but subsequent development of homosexuality in the past two years)

This patient was admitted to Manhattan State Hospital in 1931 at the age of 21 and was diagnosed as a case of dementia praecox, paranoid. According to the history, the father stated that he believed the patient masturbated, although he never observed him doing so. The patient had joined the coast guard at the age of 16, started to drink heavily, and always drank in the company of men. Before his hospital admission, he had been dating girls but his history revealed homosexual practices since he was 16 or 17. Apparently the patient consorted with men in Greenwich Village with whom he practised both active and passive fellatio. The patient admitted that he had become a "fairy" and had spent most of his time in the Village.

He began to hear voices calling him a fairy and he had guilt feelings about his homosexual affairs; he became impotent and, subsequently, was more anxious about this problem. At Manhattan State Hospital, the patient apparently adjusted fairly well, was not obviously involved in any sexual deviations and was released on convalescent status. During his convalescent care period, the patient took a job for about three months, then began to feel that people were looking at him because they knew that he was a "fairy." He attempted to have sexual relations with a girl and became disturbed when he was impotent.

In 1933, E. R. was admitted to Pilgrim State Hospital. Subsequently, it was noted that he participated in passive feliatio on the ward. He developed and expressed open ideas of hostility toward his mother. He explained this by stating that someone gave him a theory or explanation about what makes homosexuals. He said, "If your mother has many intercourses with men, you will become a homosexual." The patient slept poorly; ate poorly; roamed about the dormitory.

In August 1951, he had a prefrontal lobotomy. Immediately following the operation, and for approximately two years afterward, the patient showed considerable improvement in behavior. He became quiet and well-behaved, but was still hallucinatory. He was somewhat disinterested in his surroundings and apathetic, and it was not until the end of 1953 that he became involved in active autoerotic and homoerotic manifestations. In the beginning of 1954, he again became disturbed in his behavior and for the next two years this patient masturbated excessively, and participated in all types of homoerotic and autoerotic manifestations—kissing,

fondling other patients, engaging in active and passive fellatio. He became assaultive and disturbed, presumably because of his sexual deviations. He now has to be closely supervised; is actively hallucinating, hearing female voices and refusing to divulge their content. This patient has shown an increase in his sexual manifestations after operation.

J. C. (Unchanged sexual patterns after lobotomy)

J. C. was admitted to the New York State Psychiatric Institute in New York City in June 1938 at the age of 14. He was subsequently diagnosed as dementia praecox, hebephrenic. His history revealed that he had shown a lot of interest in the opposite sex and was particularly interested in erotic pictures of girls. On questioning, the patient disclosed that whenever he saw a girl, he would become "nervous" and would wink at her.

He was admitted to Bellevue Hospital in 1939, where it was observed that he manipulated his genitals frequently. He was admitted to Pilgrim following this, and in 1940 was described as masturbating frequently. A note states: "He sits in a chair squirming around with one hand on his genitals and the other hand in his anus." No other erotic tendencies were noted except for his frequent masturbation. In 1942, he was released on convalescent care, but while on convalescent care he lifted up his mother's dress, apparently because of his sexual curiosity.

During his following years in the hospital, it was again noted that he masturbated frequently. He was lobotomized in 1949 and released on convalescent status in 1950, but was returned because he was involved in a series of sexual difficulties. He apparently fell in love with his cousin, a married woman, and wrote love letters to her. He was described as becoming "nervous" when he saw girls on the street and apparently manipulated his genitals through his clothes. The most troublesome feature of his behavior was his intense preoccupation with girls. He kept watching his sister and saying, "Aren't you beautiful?" After the patient's return to the hospital, he did not masturbate openly. Frequently, however, the patient goes to the movies where he finds a girl with whom he "falls in love," writes numerous love letters to her, buys her lipstick and other gifts. He also requests that the girls send him money in return. On the ward, the patient caresses other patients, sits close to them but does not show any other homoerotic tendencies. The patient freely says, on interview, that he has not lost his heterosexual interests.

C. G. (Sexual manifestations disappeared after lobotomy)

This man was admitted to Pilgrim State Hospital in 1940 at the age of 19. He was subsequently diagnosed as dementia praecox, hebephrenic type. According to the history, the patient was single; never mixed with the opposite sex, was shy, and would not talk to girls. He became rather hostile toward his mother and was attached to his father. No sexual irregularities were noted by the family, but the patient admitted freely

that he masturbated privately. After admission, the patient was occasionally seen to participate in kissing and fondling on the ward. Occasionally he was observed performing active fellatio and masturbating actively. He was lobotomized in July 1951. After lobotomy, no sexual deviations were reported except that, on interview, the patient admitted occasional masturbatory practices but denied any other sexual activities.

G. A. (*No sexual deviations before; sexual manifestations afterward*)

G. A. was first hospitalized in 1941 at the age of 22. He was described as having been withdrawn and as never engaging in any heterosexual relations. Due to his assaultive tendencies, a prefrontal lobotomy was performed in 1947 at the Neurological Institute in New York, following which he showed some improvement in his behavior. However, he was subsequently admitted to Pilgrim State Hospital in 1948, at which time he was described as emotionally dilapidated, silly and unable to carry on a logical conversation. He was restless and markedly disturbed. In 1950, it was noted that he kept his hands inside his clothes, played with his genital organs and showed homoerotic tendencies, annoying other patients during the night. At present, he is described as being the worst management problem in a continued treatment building. He is severely regressed and displays his genitals openly. This patient requires constant supervision because of his sexual approaches to other patients, activities that frequently end in altercations and assaultive behavior on the ward.

T. T. (*Apparent increase in inhibitions despite continuing sexual patterns after operation*)

This patient was first hospitalized in 1942 at the age of 18, with a subsequent diagnosis of dementia praecox, catatonic. Later, this patient was involved in active and passive fellatio, other homoerotic manifestations, and overt masturbation. In 1950, he was reported to be exposing himself. In 1951, a lobotomy was performed and he improved in all respects. He became friendly and sociable, and no sexual deviations were noted for several years. In the past year, however, the patient has been observed to fondle and caress other patients and has become one of the most aggressive homosexuals on the ward. At present, he is something of a problem because of these homosexual tendencies. He attempts to hide his activity but occasionally becomes involved in altercations because of it.

F. S. (*Lack of inhibitions*)

This man has a history of many hospitalizations before his admission to Pilgrim State Hospital in 1942 at the age of 35. His previous hospitalizations were usually diagnosed as pseudoneurotic schizophrenia. However, the hospital diagnosis was that of dementia praecox, hebephrenic type. During the many years of his previous hospitalizations he had never

shown any abnormalities in the sexual sphere. In 1949, a prefrontal lobotomy was performed. In the past year he has become extremely careless in his habits; openly exposes himself; shows no respect for anyone; frequently urinates outdoors, and exposes himself even while attending social functions, such as movies and dances.

Discussion

It is to be noted that all of these patients are males who are almost all chronic schizophrenics institutionalized for at least 10 years. Most are practically inaccessible for interview and are unable to discuss their sexual problems. The indications for lobotomy in all of these patients were almost the same: that is, the patients were long-term schizophrenics who had become serious management problems for the hospital because of aggressive, assaultive, destructive and extremely unpredictable behavior. The control of this behavior was accomplished in a majority of the patients by lobotomy, but it was subsequently noted that—usually in from two to five years following operation—the patient's behavior again became a problem in management. Instead of the assaultiveness and aggressiveness, a problem in overt sexual behavior began to appear.

Many of these patients openly masturbated on the ward almost incessantly; many of them participated either actively or passively in kissing, fondling, and petting; many of them participated actively or passively in *coitus in ano;* strangely, few of them participated in either active or passive fellatio. As a result of this ward behavior, seclusion, which had no longer been necessary because of the decline in aggressiveness after lobotomy, again came into use. At first it appeared that ataractic drugs would solve the problem, but after about four months of medication, the original erotic manifestations would return.

From the writers' data it would appear that as a result of lobotomy, there was an increase in erotic manifestations. Upon closer scrutiny, however, it seems that the increase is more apparent than real. As demonstrated in one of the case histories presented, these patients manifested overt erotic manifestations before operation; but these deviations were masked by the aggressiveness and assaultiveness for which the lobotomies were done; and lack of observations by hospital personnel, also plays a role. Sexual deviations were not considered a serious management problem

before operation. Following operation, the patients became more manageable, but at the same time, the original erotic behavior was more obvious as a ward behavior problem.

Several authors have attempted to explain the more obvious erotic behavior by stating that there is a release of sexual inhibitions following operation but the present data show that there is no release of sexual inhibitions, but that sexual behavior patterns merely become more obvious. These patterns had been masked, as was stated previously. In addition, the writers do not contend that the arousal of overt homoerotic and autoerotic manifestations is the result of lobotomy. They are well aware of the presence of these patterns in chronic, long-institutionalized schizophrenics. They are also aware of the development of homoerotic and autoerotic manifestations as a situational factor in institutions regardless of diagnostic category or treatment. Nevertheless, the present observations are that the manifestations of this pattern in some postlobotomy patients have resulted in the development of severe management problems and return to the use of isolation and other forms of restraint—although, of course, not to the degree that existed preoperatively. It seems that the severe management problems, as far as homoerotic and autoerotic manifestations are concerned, are more prominent and troublesome in patients who are in a marked state of regression, the progress of which the operation did not prevent.

Summary and Conclusions

1. Sixty patients of a total of 100 show autoerotic or homoerotic manifestations five years after lobotomy. Two-thirds of the patients who show these manifestations after lobotomy have shown them before lobotomy. The remaining one-third do not constitute a real increase in such activity, but an apparent one, caused by masking of this behavior by the aggressive behavior of the patient before lobotomy and by lack of adequate observation. Therefore, the writers feel that there are no *new* homoerotic or autoerotic manifestations brought out by lobotomy.

2. Lobotomy, in the majority of cases, does not change the pattern of sexual behavior which existed prior to operation.

3. The preoperative sexual pattern was masked in some patients, giving rise to the belief that lobotomy increases the autoerotic

and homoerotic manifestations, but this belief was not borne out by the writers' data.

4. It is the writers' conviction that release of sexual inhibitions is not a predominant factor in the increase or decrease of post-operative homoerotic and autoerotic manifestations in hospitalized patients.

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TERMINATION OF TREATMENT AGAINST MEDICAL ADVICE*

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While laws concerning legal certification have undergone relatively few changes, the status of patients in modern psychiatric hospitals has, nevertheless, been significantly altered during the past 25 years. Due to new and more effective methods of treatment and the increasing acceptance of psychiatric illnesses on an equal basis with those of other branches of medicine, a greater number of patients are being admitted to general hospitals for active psychiatric treatment on a voluntary basis, regardless of the nature or severity of their illnesses. Many acutely ill patients are now being treated in less restricted settings with less need for restraint and special nursing care. Treatment under such circumstances, however, is often challenging and poses numerous problems about which there is little in psychiatric literature. The present study, based upon clinical and administrative experience at the Payne Whitney Psychiatric Clinic of The New York Hospital, New York City, is primarily concerned with those particular problems which arise when voluntary in-patients refuse to accept and continue necessary treatment.

When it has been clearly established that a voluntary in-patient is of danger to himself or others, he may be held against his will, in spite of his request for discharge, until a transfer and certification to another hospital is effected. When danger to himself or others is possible but cannot be clearly established, the patient may be released from the hospital to a responsible person against medical advice. In such instances a relative, or a lawyer or physician is requested to sign a release-form, witnessed by the physician in charge, since the patient cannot be expected to understand the medico-legal implications of his discharge. Signed releases, however, may be challenged, since the relative as well as the patient may later be considered to have been unable to comprehend the inherent dangers of discharge for which the physician in charge should have assumed full responsibility.

Since the danger of suicide is in most cases the major reason for retaining or discharging psychiatric patients against medical advice, the risk involved must be carefully evaluated, and when-

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ever possible, by more than one member of the medical staff. The degree of risk of suicide is directly related to such factors as the patient's unrecognized hostility, the depth of depression, marked guilt with a need for atonement, dreams of death, a family history of suicide, a history of previous suicide attempts and suicide ideation. The risk of suicide may be lessened if the discharged patient can be persuaded to continue treatment on an out-patient basis or with a private therapist. In general hospitals which maintain both in-patient and out-patient departments, the treatment of selected patients may be continued within the setting of the same institution, thus avoiding the total break which follows discharge from isolated state and private psychiatric hospitals. The risk of suicide may also be lessened if environmental factors are altered in such a way as to decrease the stress which existed before the patient's hospital admission. Unnecessary risks may be avoided by alerting relatives to dangers of suicide and their management, and by offering further assistance to the patient, as well as to his family, in spite of the nature of his discharge.

During the period between January 1952 and January 1958, 44 in-patients of the Payne Whitney Clinic were discharged against medical advice. Although only eight of these patients had made suicide attempts prior to admission, all revealed evidence of previous thoughts of suicide. Nineteen patients in this group were schizophrenic with paranoid features predominant; 15 had affective disorders, characterized by depression and suicidal ideation; five had psychoneurotic depressions; four had character disorders with depression and alcoholism; and one patient had an organic reaction with depressive features. Termination of treatment against medical advice was most commonly due to the patient's lack of insight, and to resentment toward restrictions of the hospital. Fear, distrust, feelings of rejection and hopelessness, an unsatisfactory doctor-patient relationship and concern for social stigmata also played a dynamically significant role in the therapist's failure to convince these patients and their relatives of the need for further treatment. Those who were discharged within a few days after admission had either reacted to confinement with marked fear and resentment or had made rapid symptomatic recoveries without insight into the seriousness of their illnesses. Those who were discharged after prolonged periods of treatment, with privileges of visiting out of the hospital, were unable to

accept the renewed restriction necessitated by exacerbations of symptoms. Those few who were readmitted to the hospital refused again to continue voluntary treatment.

Available follow-up reports revealed that seven of the 44 patients discharged against medical advice continued treatment on an out-patient basis or with private therapists, while 11 were readmitted involuntarily to other hospitals. Three committed suicide within a few days following their discharges. All three had made suicide attempts prior to admission.

In all cases, termination of treatment against medical advice was dynamically determined by one or more of the following factors: (1) the nature of referral and admission; (2) environmental and cultural factors; (3) the attitude of relatives; (4) the patient's psychopathology; and (5) therapeutic methods and skills.

Referral and Admission

A referring physician determines to a considerable extent the eventual outcome of his patient's treatment. Nonpsychiatrically-oriented physicians in particular may themselves reject psychiatry or fail to understand the indications for admission to a psychiatric hospital. Furthermore, hospitals differ in their therapeutic facilities, and, therefore, may necessarily be selective with regard to the types of patients that they accept.

When a patient is realistically informed of the nature of his illness and adequately prepared for admission to the hospital, his acceptance of treatment is more assured. When deceived or inadequately prepared, he may react with fear and hostility and demand his release. Consequently, treatment may be terminated shortly after admission, and the chances for eventual recovery are seriously jeopardized thereby.

The skill and judgment of the admitting physician will likewise be a determining prognostic factor, since it is he who makes the first contact with each new patient. It is his responsibility to determine those factors which either indicate or contraindicate voluntary treatment. When a patient is acceptable for voluntary admission, the physician should make certain that a responsible relative will be available throughout the course of treatment, since there may be considerable risk in releasing the patient at a later date, upon his own request and to his own custody. Whenever possible, each new patient should be informed that admission is

voluntary, that every patient is expected to benefit from treatment, that electric convulsive or insulin treatment will not be administered without his consent, and that the restrictions to be imposed are not only determined by his subjective symptoms but also by his needs for nursing care and his social behavior. The admitting physician's ability to obtain a complete but concise history from both the patient and his relatives, his evaluation of the patient's psychopathology and therapeutic needs, and his judgment in the selection of a therapist will significantly influence the course of hospitalization.

Environmental and Cultural Factors

When treated in a psychiatric division of a general hospital, patients are more likely to display less concern for public opinion and are better motivated to assume a greater degree of therapeutic responsibility than if they were in a "mental institution." Furthermore, close contact with other medical specialties serves to assure the patient that organic factors will not be overlooked in the total evaluation of his illness. However, financial hardship, responsibility for dependents, fear of loss of employment and fear of the dissolution of a marriage are frequent concerns which may result in a request to discontinue necessary treatment. Therefore, every effort should be made to alleviate these concerns prior to admission by realistic consideration of the patient's ability to support treatment financially, and by consideration of the care of his family and his employer's co-operation.

The high proportion of female patients in a private psychiatric hospital appears to be directly related to an economic factor. Most of them are dependents and consequently are able to rely upon male relatives for continued financial support. Many male patients who are without income because of illness are unable to afford prolonged, private treatment and may be compelled to seek private charitable assistance, or to enter public hospitals. Financial stress frequently accounts for requests to terminate treatment prematurely.

Although a history of psychiatric illness, particularly when treated in a hospital, may constitute a handicap where employment is concerned, fear of social stigmata is less frequently given as the basis for termination of treatment by those who are well established and secure in their chosen careers.

Attitude of Relatives

Undue pressure or threats by relatives at the time of admission may seriously interfere with a patient's therapeutic progress. The resentment which ensues may be displaced onto the hospital, as a means of justifying a request for discharge and failure to profit from treatment. A negative reaction or aversion to the hospital may also serve to conceal other sources of resentment in intrafamilial relationships. Psychopathologic interactions between a patient and his relatives may be manifested by fluctuations in the emotional stability of both. A patient's failure to improve may give rise to anxiety, guilt or unrecognized hostility in a relative, who proceeds to rationalize the removal of the patient from the hospital on the basis of social stigmata or a professed need for the patient at home. When relatives are overdependent upon the patient, fear his retaliation, feel guilty and responsible for his illness or feel themselves threatened by the patient's treatment, they may proceed to give in to his demands and remove him against medical advice.

The co-operation and understanding of relatives is needed if one is to pursue a voluntary patient's treatment to successful completion. Therefore, it is important for the therapist to establish early contact with relatives, to keep them informed of therapeutic progress, and to educate them about the nature of the patient's illness. The degree of contact between the patient and his relatives through correspondence, telephone calls and visits should also be given due consideration in the total plan of treatment. Individual or group therapy for relatives may prove to be of value, particularly when their lack of co-operation is psychopathologically determined.

The Patient's Psychopathology

A patient's psychopathology, more than any other factor, dynamically determines his willingness or unwillingness to accept treatment. Patients who recover from an acute excitement or panic reactions and return to their pre-illness adjustments within a relatively short time have considerable difficulty in accepting continued treatment for the purpose of assuring a more or less permanent recovery. Regardless of adequate preparation for admission, patients who are rigid, domineering, resentful of authority and intolerant of restrictions will often succeed in forcing rela-

tives to agree to early termination of their treatment against medical advice. Manic patients may be particularly resentful of hospital restrictions, because of lack of insight and the subjective feeling of wellbeing. Depressed patients are more co-operative, unless paranoid features are prominent. When a patient has been admitted to a hospital following an attempt at suicide, an adequate period of observation is necessary before one can agree to his demands for discharge. Patients who have contemplated suicide in the setting of a depression generally accept advice to continue in-patient treatment until reasonable assurance can be gained of their future wellbeing.

The retention of patients with character disorders who have made impulsive and histrionic suicide attempts requires far greater therapeutic skill, since these patients have little awareness of the medical and social significance of their behavior. Restrictions on acting out, which are an essential part of their treatment, usually give rise to resentment and consequent demands for release from the hospital. It is this group of patients who most commonly threaten legal action on the basis of false detention or imprisonment. Patients who present histories of having been repeatedly discharged against medical advice from other hospitals are generally not suitable for voluntary admission to the psychiatric service of a general hospital, and should be referred to a hospital where they can be accepted as voluntary patients but detained legally if necessary for uninterrupted treatment.*

A patient's unwillingness to accept voluntary treatment may also be related to such factors as fear of dependency upon the hospital, unfavorable interactions with other patients, increased fear of illness, and negative transference reactions.

*A patient on the psychiatric service of a general hospital in New York State is a voluntary patient in the sense that he would be on any other service of the hospital; he cannot be retained against his will. A state hospital, or a private hospital that is licensed for the treatment of the mentally ill, can retain a voluntary patient (one who enters voluntarily) if necessary by taking steps for his certification. At the Payne Whitney Clinic, if a psychiatrically ill patient insists upon discharge when it is plainly indicated that he should be treated in a psychiatric hospital, immediate steps are taken to transfer him to a private licensed institution, or to the psychiatric division of Bellevue Hospital, where his ultimate disposition may be determined. It is very unusual for such a step to be necessary.

Therapeutic Methods and Skills

New somatic methods of treatment have not only reduced the number of psychiatric patients who need hospitalization but have also made it possible for greater numbers to be discharged at earlier dates. Relief from symptoms may enable a patient to be more amenable to psychotherapy but may also result in his failure to recognize the still persistent seriousness of his illness and the need for continued treatment.

The success or failure of treatment is also dependent upon the skill and experience of the therapist. His ability to satisfy the patient's needs within the setting of a hospital is directly related to his early understanding of all those factors which are dynamically significant in psychopathological reactions, whether they be physiologic, psychologic, social or cultural. A patient's initial adjustment to the hospital environment is dependent upon the promptness with which the therapist makes contact with the newly admitted patient, the manner in which he orients the patient to the hospital routine, the information which he imparts to the nurses and other members of the professional staff and the thoroughness of the physical examination.

In a teaching hospital, the outcome of treatment will depend to a considerable extent upon the resident psychiatrist's maturity and the amount of supervision he receives. When in the early stages of training, the young psychiatrist is in particular need of assistance with transference and counter-transference reactions. His patient's failure to cope with the reality of hospital treatment may reveal his own feelings of insecurity or of conflict with authority. Termination of a patient's treatment against medical advice may also be due to the resident's emotional involvement with, or neglect of, relatives who are themselves anxious and threatened by treatment.

Summary and Conclusion

The increasing number of psychiatric patients who are being admitted voluntarily to psychiatric divisions of general hospitals for active treatment has given rise to a number of problems about which there is little in psychiatric literature. This study is primarily concerned with those particular problems resulting from the refusal of voluntary in-patients to accept and continue necessary treatment. During a period of six years, 44 voluntary patients were discharged from the Payne Whitney Psychiatric Clinic

against medical advice. In all cases, a suicide risk was involved but could not be sufficiently established to warrant transfer of the patients to other hospitals for certification. The majority of these patients were diagnosed as schizophrenic with paranoid features or as having affective disorders with depression. In spite of all possible precautions, three patients committed suicide shortly after discharge.

Termination of treatment against medical advice was most commonly due to lack of insight and resentment toward the restrictions of the hospital. Either fear and resentment or a rapid symptomatic recovery was primarily responsible for discharges which occurred within a few days following admission, while an exacerbation of symptoms usually accounted for premature termination of treatment after prolonged hospitalization.

In all cases, termination of treatment against medical advice was dynamically determined by one or more of the following factors: (1) the nature of referral and admission; (2) environmental and cultural matters; (3) the attitude of relatives; (4) the patient's psychopathology; and (5) therapeutic methods and skill. The success or failure of voluntary psychiatric treatment within the setting of a hospital is dependent upon the therapist's early understanding of all the factors which are dynamically significant in psychopathologic reactions, whether they be physiologic, psychologic, social or cultural. A therapeutic failure may be directly related to a resident psychiatrist's lack of experience and, therefore, may be an important aspect of his training. Dynamically-oriented follow-up studies of patients who terminate treatment against medical advice are needed for a clearer understanding of the indications and contraindications for voluntary admission to a psychiatric service of a general hospital.

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CULTURAL PERSPECTIVES IN RESEARCH ON SCHIZOPHRENIAS: A HISTORY WITH EXAMPLES

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A group of disorders known as the schizophrenias has long perplexed psychiatry. The French psychiatrist, Morel, called them dementia praecox, meaning a serious pathological state beginning early in life. Equally fatalistic, Kahlbaum's descriptions in German distinguished certain types in 1863 and 1874, each one having an insidious and disastrous course. Before the end of the nineteenth century, Kraepelin had published his famous classification of 1896 in which he argued that each type of schizophrenia was an organic or endogenous illness and one not due to external causes. At first, Kraepelin felt that this organic pathology was centered in the brain, but later he observed striking differences in the forms and frequencies of the illnesses occurring in Java, Malaya and elsewhere. By this time, Bleuler had influenced Kraepelin to add a fourth type, simple schizophrenia, to the three types of illness originally named by the latter. But Kraepelin's more important concession to environmental explanations was to shift to discussions of metabolic disorders as accounting for the different forms and frequencies of the schizophrenias in various populations of the world.

Bleuler's classic, *Dementia Praecox or the Group of Schizophrenias*, appeared in 1911. Where Kraepelin had contrasted populations from far-flung regions of the world, hinting at racial and constitutional differences, Bleuler focused on a narrower range of peoples—from Holland, Thuringia, Upper Bavaria, Saxony, and even the people of Berne and Zurich. The latter were certainly similar in physique, but they had "different reactions." Bleuler mentioned Irish and English differences in the state of illness. He adduced the work of Kraepelin and Ziehen where they had observed epidemiological variance in several populations. Bleuler not only noted differences among peoples of similar racial type and discarded Kraepelin's metabolic explanation, but he described various *psychological processes* where Kraepelin had discussed *symptoms* and had ascribed them to organic causes. Bleuler, therefore, noted that a psychological process can underlie a cluster or pattern of symptoms and their accompanying organic states.

In such illness states, patients were responsive to the impact of environmental conditions. Their individual reactions could be deflected, arrested or channeled into new courses, depending on the treatment applied. Bleuler's assertion that certain types were responsive to given treatments was strengthened by his observation of spontaneous remissions in others. He introduced the hope that the schizophrenias were open to treatment and voiced his belief that factors of group background "and external circumstances should be found."

While Bleuler was interested in the epidemiology of the schizophrenias, the passages in his great book are tantalizingly brief on this subject. One must look further to find a public health, or preventive, approach to this problem. Even before Bleuler, however, the reformist setting of post-revolutionary France had provided the answer. Pinel's student, Jean-Etienne D. Esquirol (1772-1840) wished to sharpen the acuity of clinical observations with a more psychological, as well as quantitative, approach to the emotional life. In a reaction against the rationalists of the Enlightenment in France, Esquirol charged that they were preoccupied with intellectual aspects of mental disease and with the pigeonholes of classification. Instead, he said, one must stress the roles played by emotions and values in human relations. Realizing that information of such a type was difficult to perceive and to accumulate systematically, Esquirol favored the gathering of statistical or epidemiological data with a view to preventive techniques in even the most serious schizophrenic disorders.

The convergence of these psychological, environmental and preventive approaches was developed in the American scene by Adolf Meyer (1866-1950). At the Henry Phipps Psychiatric Clinic of the Johns Hopkins Hospital, Meyer and his colleagues built solidly on these earlier foundations. Preventive psychiatry was emphasized in the term, "mental hygiene," which Meyer found in the earlier literature but succeeded in popularizing. His system, called "psychobiology," recognized each patient's problem as a complex of biological, psychological and environmental influences reflected into his total personality. This encompassing view was called "a distributive analysis of relevant factors," but it led to the first massive epidemiological study of mental illness in urban surroundings, that made in the Eastern Health District of Baltimore. This striking research including the schizophrenias,

was carried out by Lemkau, Tietze, Cooper and others in an interdisciplinary team of behavioral scientists.

Meyer not only stimulated epidemiological research, but, like Bleuler, he stressed the existence of several types of schizophrenia and differences in their prognoses or probable courses of illness. The responses to environment in every phase of their development or treatment were influenced by the psychological and cultural factors entering into a patient's self-conception or self-deceptions.

Contemporaneously with Bleuler in Switzerland and Meyer in America, the Freudian movement became interested in treatment of milder neurotic disorders. Meyer's notion of conflicts growing "realistically" out of experience and promoting habitual incapacities was replaced with conflicts dependent upon deeply rooted unconscious drives. Meyer's concept of the larger environment and its life-long impact was shrunk to the narrow proportions of early parent-child and sibling relationships almost exclusively. Despite this, the Freudian system contributed heavily to an understanding of schizophrenia. Pierre Janet had earlier spoken of "the loss of a sense of reality." Bleuler had described "conflictual ambivalence," a concept borrowed from Freud, as leading to the withdrawn or shut-in "autism" characterizing certain kinds of schizophrenia. In the Freudian system, the loss of reality contact was linked to the flooding of impulses from unconscious dynamic or symbolic sources, often poorly controlled and little understood by the patient. There was a defensive substitution of a world of one's own where reality failed. While the focus was upon the defensive mechanisms themselves, obviously an environmentalist revision of the system could point out that they were used against the stresses of life experiences and within social settings. If such defensive mechanisms distorted reality, how could they become habitual unless growth was blocked or reality appeared to be threatening?

It is clear that psychiatry had succeeded in typifying the general nature of the schizophrenias, while remaining largely preoccupied with the cause and course of these diseases in individuals rather than in groups. Today, more is known about the particular needs of a given case than about general detection or prevention in the community. Psychiatry has delineated types and discovered processes in the schizophrenias, but has only occasionally considered epidemiological backgrounds, or promoted a general un-

derstanding of the nature of the schizophrenias. In quite another field of science, anthropology has busied itself with the aspects of human existence that distinguish one group from another. It has located, in cultures, compelling and pervasive meanings which influence behavior. In brief, psychiatry as a medical science perfected knowledge of patterned behavior in individuals and in pathological states studied in Western European cultures. Social science studied patterned behavior in groups, with emphasis on ranges and contrasts in conduct, both normative or "normal" and aberrant—and located throughout the world.

Recently, social psychiatry has been developed to bridge the gap between such constantly converging fields. For example, the World Health Organization commissioned a British psychiatrist, J. C. Carothers, to gather data on mental illnesses in Africa. This resulted in a monograph in 1953, bristling with regional variations. The present author, in the same year, began a more comprehensive survey of the distribution of various types of mental illness among the peoples of the world. This work was published in 1956 under the title of *Culture, Psychiatry and Human Values*. Again, wherever reliably reported, epidemiological and acculturation studies showed various symptom pictures and led to consideration of their differing etiologies.

For one thing, it appeared that mental illnesses differed from the organic deficiency diseases, or from germ-specific ailments in several ways. In the schizophrenias, for example, they drastically and dramatically involved the total personality. Second, they often implied the instability and disturbance experienced by groups of individuals in their cultural environment. Third, and reflecting upon the recent overoptimism about "tranquilizers" and "wonder drugs," these serious illnesses had for decades defied the search for easy solutions and, instead, had required a whole process of re-education over a stretch of time. Because of their insidious nature, because of the total personality involvement, and, in particular, because of environmental influence, it seemed, especially in the schozophrenias, that attention was being focused upon the discrete individual all too exclusively. Most conceptions of schizophrenia implied—despite Bleuler, Meyer and Freud—only the private aberrations of essentially deranged minds.

It seemed, however, that typical strategies of research in public health and preventive medicine might be applied in this situation.

In organic illnesses, such methods had proved valuable. Haven Emerson, in 1913, had found ethnic, or cultural, differences in measles, diphtheria and scarlet fever rates which proved important in understanding the transmission of these communicable diseases. The year following, Clifford Abbott used the same methods to explain endemic developments of simple goiter. W. L. Aycock and J. W. Hawkins surveyed regional, cultural and family relationships in leprosy, and R. D. Friedlander did so for pernicious anemia. In New York State, M. Calabresi had found different rates for diabetes, heart disease, pneumonia and tuberculosis among persons of Italian, Irish, German, Polish and British extraction. Following the Bigelow and Lombard studies in 1933 on the different frequencies of cancer at certain sites, H. F. Dorn and M. E. Patno each, in 1954, revived the case for ethnic differences in cancer development. F. R. Smith, in 1941, and E. L. Kennaway, in 1948, discussed cultural background differences in cervical and uterine cancers. A social scientist, Saxon Graham, reported a county in Pennsylvania where rheumatism, arthritis, high blood pressure and diabetes showed low rates in the first generation of some ethnic groups, with an increase in the second generation and leveling off in subsequent generations.

A few of these illnesses had been asserted for some time to be psychosomatic in character. H. Blotner and R. W. Hyde noted in 1943 the high incidence of certain forms of diabetes in the Irish and Jewish male populations. Others noted high rates among Italians. Alcoholism was found among Irish to be a common accompaniment of more fundamental personality disorders. On the other hand, Diethelm's recent book on chronic alcoholism notes that certain groups, like the Chinese in New York, are free of this symptom for a variety of social and cultural reasons. Haggard and Jellinek specify almost equally low rates of alcoholism for Italian and Jewish populations.

Klopfer, in the PSYCHIATRIC QUARTERLY of 1944, and Malzberg even earlier reported finding different frequencies in major mental illnesses among such groups as Italian, Irish and German immigrants. In the same year as Klopfer's report, R. W. Hyde and associates found striking variations in Selective Service rejectees from the Boston area. Again such groups as persons of Chinese, Irish, Italian, Jewish and Portuguese derivation were compared, although unfortunately such gross diagnostic categories

as psychoses, neuroses, mental deficiency, psychopathic personality and chronic alcoholism were used. Only studies by E. Stainbrook in the Bahian region of Brazil or J. C. Carothers' compendium of African data discussed schizophrenia centrally, and even these authors discerned diagnostic variations more than differences in the etiology and developmental course of the diseases. When one turned to the *Diagnostic and Statistical Manual on Mental Disorders,* developed by a committee of the American Psychiatric Association, there was no clue to a cultural etiology. Nine headings were utilized for schizophrenic illnesses, exclusive of such personality disorders as "schizoid personality." Kraepelin's subtypes, like the hebephrenic or catatonic, were preserved to emphasize certain clusters of symptoms, but the symptoms themselves were overlapping; and the older terminology of autism, hallucinations and disturbances of thought and affect was recurrent throughout the list.

The crucial point is that the correct weighting and profiling of symptoms makes etiological sense about why one specific illness has developed and not another. Only this can provide a differential diagnosis. Extensions of our knowledge of the psychotherapy of the schizophrenias, by Sullivan, Diethelm, Hill, Fromm-Reichmann and others, have suggested that interpersonal relations and stresses implicit in various cultural backgrounds are basic, perhaps, to different disease processes.

The author had explored this hypothesis earlier. In the period from 1938 to 1943, he studied small samples of schizophrenics at Morningside Hospital in Portland, Oregon, and noted differences in patients who were Eskimo, Aleut, Tlingit or Tsimshian in cultural background, and further differences in those who were Alaskan whites. The hospital was a federal institution for persons from Alaska and surrounding regions. Unfortunately, the samples were inadequate and represented only persons hospitalized in the five-year period. However, they did bring differences in cultural background and acculturation processes into focus. Along with these factors went distinctions in disease development and indications, useful for the psychiatrist, as to possible treatment.

It appeared that the schizophrenias are not a collection of airtight entities since different cultural backgrounds defined variations in family and social structures that were reflected in pathol-

ogy. In this way, the schizophrenias could highlight, rather than obscure, severely emotionalized conflicts rooted in culture. It was the latter element which had provided the family or the individual with systems of value, habits of thought, patterns of action, and even the attitudes toward interpersonal relations which proved to be so fundamental.

In 1954 and 1955, following studies of eight ethnic groups, it was decided to study hospitalized schizophrenic samples of certain cultural backgrounds. The backgrounds of the community groups from a section of New York City, were of Irish, Italian, German, Hungarian, Czech, Slovakian, Puerto Rican, and older American types. The schizophrenic samples from the same area that are reported on here were of Italian or Irish background. Besides the aim of exploring culture differences in the schizophrenias, it was hoped to provide a check on data that had been obtained from random samples of persons residing in each functioning ethnic community. For each study, the normative community in New York, with its functioning picture of family life, good and bad, provided all the hypotheses necessary for understanding the schizophrenic illnesses in each specific group.

In the community, anthropological field surveys were used; questionnaires were applied to a random sample of adults; and intensive family studies of subsamples were made. In the hospital, it was possible to amplify these methods of community research with anthropological interviews and observations of patients; with psychiatric records and conferences; and with an independently operated battery of 13 psychological tests. The psychological test battery was devised by clinical psychologists of the Franklin D. Roosevelt Veterans Administration Hospital, and in particular by Dr. J. L. Singer and his staff at the hospital. The project as a whole was designed by the author, who assumed responsibility for assembling the anthropological data. He worked with patients, with the psychiatric staff, with preliminary records of psychiatrists, social workers, nurses and occupational therapists, to develop a complete account running parallel to the psychological tests. When the data were completed on the entire samples of Italian and Irish patients, the author and Dr. J. L. Singer intercompared their independently gathered data on each sample.

The samples resulted from a complete census of four contiguous hospital buildings conducted by the author. All female schizophrenics of Irish or Italian background had previously been studied to determine—besides the community studies—differences in male and female roles in illness states. These samples of female patients were inadequate statistically, but interesting on psychodynamic grounds. The male patient census of four buildings drew samples of 40 Irish and 37 Italian male patients, each clearly diagnosed as schizophrenic. These represented the field study area. Patients were accepted for the sample only if without record of cerebral damage and if they had not been involved in psychosurgery. Practically all had received shock therapy. Other than this, no organic causation nor treatment beyond the usual barbiturates had been recorded.

The patients, entirely by chance, were limited to the first, or immigrant, generation; the second or that of children of immigrants; and the third. When all 77 subjects had been studied intensively by anthropological interviews, psychiatric methods and complete hospital records, each was referred to the clinical psychology staff composed of Dr. Singer and colleagues. Among the psychological instruments, reported on elsewhere, it was decided to use the Rorschach, Barron's Movement-Threshold Inkblots, the Porteus Maze, the Thematic Apperception Test, Time Estimation and Motor Inhibition Tests, the Lane Sentence Completions, and other behavioral ratings. These instruments, plus anthropological interviewing and ward observations provided independent ratings of functioning to which the patient's history and consultation with psychiatrists could be added. Ten Irish and seven Italian patients were too ill to complete the test battery and were studied independently by the combination of anthropological and psychiatric means. They are not included in the tables which follow, since psychological tests were incomplete. However, they conform closely to the differential pattern of their ethnic groups as hypothesized and as found in matched samples of 60 patients, 30 Irish and 30 Italian, studied by all three methods, psychiatric, anthropological and psychological.

In the matched samples of 60 patients, the mean age of the Irish was 32 years as compared with the mean for Italians of 30.5. (Age limits for both groups were 18 to 45 at the beginning of the study, when the census was taken; it had shifted, of course, to 20 to 47

two years later when the study was completed.) For the last grade of education, an Irish mean of 10.5 grades matched the Italian of 10.9. The intelligence potential, computed in Wechsler IQ averages, and again by means, disclosed an Irish sample of 108.4, closely matching the Italian 105.5. Length of hospitalization was hardly different, with a mean for the first year of 1949.8 (or .8 of a year after 1949) for Irish and 1949.5 for the Italian. In marital status, by actual count, 25 Irish and 22 Italians were unmarried; and none of the comparatively few marriages of the remaining patients could be counted distinct successes when studied. The variables matched or controlled for both samples were, therefore, age, sex, educational level, intelligence, first year of hospitalization, marital status, absence of organic or chronic conditions, and origin in the field study area. Only marital status showed, for the Irish, a slight and possibly culturally-influenced excess of bachelorhood. Yet illness and its particular pathology had made both groups primarily celibate, as will be seen.

Regional differences are important in Italian culture, less so among the Irish. As concerns this variable, the writers were again fortunate in eliminating it along with those just compared. All Italians but one could trace ancestral lines from the extreme south of Italy (Naples southward) or from Sicily. Luckily, all the Irish traced their ancestry to "southwest" Irish counties and villages. The one lone north Italian who occurred in the census and came into the sample consequently proved to be an interesting exception to the Italian group in both his psychodynamic and cultural patterns.

The table, which will follow, summarizes seven variables in a total of 10 that were found to be significant in distinguishing Irish and Italian male schizophrenic patients. Earlier, at the outset of the research, it was hypothesized that these differences accounted for two patterns, highly contrasting, in the etiology of each type of schizophrenia. The discussion of them may begin by an explanation of the differential terms used in accounting for each variable.

For reasons to be given, it was hypothesized that members of neither group would have clearly male sexual identifications in the illness state. Schizophrenics are notoriously troubled by homosexual strivings. However, it is of great importance in the total balance, or imbalance, of personality, how such sexual strivings

are shaped and whether they are latent or overt in character. Certainly, Italians stress even more forcefully than the Irish the importance of masculinity for the male and femininity for the female. However, the Italians also emphasize the expression of sexuality, as they do that of any other human emotion or passion. In males who are schizophrenically ill and in whom both self-identity and sexual identification become impossible, the Italian model hypothesized was overt homosexuality, or a confused and active bisexuality which refused to pattern directly after the clearly male image of dominant and authoritarian fathers and elder brothers. Most of the Italian patients in this series were, indeed, younger siblings who had moved quickly and impulsively, judging by their life histories, though a confused latent phase of sexual repulsion from a male role and into overt manifestations of homosexual behavior.

The Irish by contrast, both in hypothesis and in fact, were fearful of a male role but repressive of homosexual trends, reactions based primarily on anxious attitudes toward mothers and other female images. One Irish patient who escaped this latent homosexual trend lost his mother at the age of three but was still fearful of domineering women. Another solved the problem by passively attaching himself to a woman exactly twice his age whom he exploited economically in her confused senility. The vast majority of Irish male patients were latent homosexuals who avoided the female world, but repressed overt manifestations.

In keeping with these characteristics, the majority of the Irish patients struggled with sin and with preoccupations of guilt concerning sexuality, whereas the Italians had no sin or guilt preoccupations in this area. Instead, the Italians' case histories and their current ward behavior showed disorders in the realms of poorly controlled impulses, weak personal attachments and widely fluctuating—or flighty—affects. The attitudes toward authority in the two groups diverged in parallel fashion, the Italians having been verbally rejecting or actively flouting of authority, as shown in tests or case history, while the Irish were hypothesized to be compliant for the most part, with only the most passive forms of outward resistance in evidence.

The delusions, based on compensatory imagination in schizophrenics, it was hypothesized, would become fixed in Irish patients, and assume the typical paranoid forms of omnipotence, or suspi-

ciousness and persecution. While delusions are ordinarily developed in many forms of schizophrenia, it was hypothesized—on the contrary—that they would be largely absent among the Italians, or, if present, would rarely be systematized or maintained with great fixity. As hypothesized, practically none of the Italians had the highly systematized and elaborated delusions found frequently in the Irish patients, so that the table deals only with the other factor of fixity.

On the other hand, for reasons of their clearer bodily emphasis, or in Schilder's phrase, "body image," it was expected that Italian schizophrenics, male or female, would be given to hypochondriacal compliants and to somatic or bodily preoccupations.

As concerns alcoholism in case histories, this was expected to be found more frequently in Irish patients than in Italian. The accompanying table summarizes these seven variables, which must then be considered in their meaningful etiological sense.

With a skeletonized set of differences between the two samples indicated in the table, it remains to account for the development of each kind of pathology. The previous community surveys in New York City contained, for each ethnic group, a whole continuum of persons and families whose behavior ranged from normative or "normal" standards of conduct to those who were aberrant or deviant. When one had studied healthy, or moderately ill, Irish and Italians in their family settings and community groups, one could distinguish the characteristic cultural contributions and backgrounds, and the particular pace of cultural change for each group, with its typical or special patterns of stress in family conflicts. Each ethnic group, Irish, Italian, Puerto Rican or other, sanctioned or interdicted outlets for emotional expression. In the range of persons and families from the healthy and well-balanced to those evidencing pathology, the cultural patterns —even where undergoing change—provided the necessary framework for understanding the meanings of emotional stress and conflict, both in pathogenic families and individuals and in those who seemed to be symptom-free. The crucial point for each cultural group of the eight studied was that it was the normative side of the continuum, the on-going ethnic group, which helped define the kinds of conflict or repression, the types of emotional expression, the system of values, or the functioning of the family for each individual.

Significant Variables in Irish and Italian Patients*

	Irish	Italian	Total
Variable 1: Homosexual types			
Latent	27	7	34
Overt	0	20	20
Total	27	27	54
Variable 2: Sin and guilt preoccupations			
Present	28	9	37
Absent	2	21	23
Total	30	30	60
Variable 3: Behavior disorder			
Present	4	23	27
Absent	26	7	33
Total	30	30	60
Variable 4: Attitude toward authority			
Compliant	24	9	33
Rejecting	6	21	27
Total	30	30	60
Variable 5: Fixity in delusional system			
No	7	20	27
Some	23	10	33
Total	30	30	60
Variable 6: Somatic (Hypochondriacal) complaints			
Present	13	21	34
Absent	17	9	26
Total	30	30	60
Variable 7: Chronic alcoholism			
Present	19	1	20
Absent	11	29	40
Total	30	30	60

*Statistical measures indicated that each of these variables was highly significant in delineating differences between Irish and Italian schizophrenics.

While Freud stated long ago that neurosis is the price paid for civilization, the writer found that each culture or subculture contained its designs for living. In each, consequently, there were various stresses and strains, and there were well-functioning families, as well as pathogenic ones. Creative and negative features typified the genius and the pitfalls of each cultural system. Therefore, the writer conducted no such search for a single etiology of a mental illness as characterized inquiry in the nineteenth

century. Instead, he insisted upon viewing every family and every patient in their meaningful cultural settings.

Therefore, three variables not included in the table were considered of primary significance. All were earlier-acting in relation to life history than those in the table. The first (Variable A) dealt with the possibilities in each cultural group, by virtue of its family system, for the development of negative and destructive emotions of various sorts. While it is true that, in the schizophenias, elements of hostility and anxiety may co-exist in different degrees, the amount of each emotion in such admixtures, and the means by which it is expressed or controlled, are crucial matters. D. H. Funkenstein's contrast between anxiety states premised on fear and those based upon hate is relevant here. This dichotomy in the schizophrenias (fear versus hate) was taken into account, together with psychoanalytic estimates as to whether these emotions were expressed or denied outlet in typical family structures of a cultural group.

It was noted that in Irish families, particularly in those poorly organized, the central figure is usually the mother. Her authority extends to all matters of household management, including not only child-rearing but the major decisions governing the home. She achieves this status by reasons of her matronage and not infrequently conceives of the distaff as the symbol of authority, of family domain and of emotional control. Historically, fathers in the southwest Irish counties were frequently in straitened economic circumstances, and were shadowy and ineffectual figures in the home. It was hypothesized, on the basis of this family structure, that anxiety, tinged with fear and hate, would be the resultant emotion in Irish male patients who as sons had been raised to view themselves as "forever boys and burdens." In two-thirds of the Irish cases, this primary anxiety (with some hostility usually compressed by fear) was directed toward all female figures. In only three cases of a total 40 did the father appear more centrally, and in these three the entire pattern of illness shifted to the Italian model in most details. In one of these, as already stated, the mother had died when the patient was three.

In sharp contrast, Italian cultural values set greater store on male parental or eldest-sibling dominance while at the same time reinforcing more direct expressions of the resultant hostile emotions. This acting-out of feelings brought more hostility to the

fore in poorly repressed conflicts with fathers or elder male siblings. One Italian patient, for example, entered the acute phase of illness at the time of his older brother's wedding and expressed himself with floridly violent accusations against his father. In practically all cases, there was a strong repulsion from the father, elder brother and even surrogate authority figures. The Italian mothers, in such instances, were often subtly rejecting and preferred the oldest son. In some cases, the mother, playing a subordinate role in the family, had compensated by assuming a mildly seductive and pampering role in relationships with the son. One could trace the effects of a harsh and punitive, domineering father. The mother compensated for her own feelings of neglect at the father's hands by building up hostile forms of impulsiveness in these sons, along with features of poor emotional control.

Italian patients, even where labelled like Irish as schizophrenics with paranoid reactions, had more prominent problems of emotional overflow (schizo-affective features) which took the form of elated overtalkativeness, curious mannerisms, grinning and laughing hyperactivity, and even assaultiveness. Even hostility directed toward the self came into evidence when elated excitements gave way to inept suicidal attempts. One-third of the Italian sample showed such periodic excitements, with confusion and emotional lability (catatonic excitements) while the other two-thirds were subject to extreme mood swings in which the depressed and quiescent periods gave way to destructive outbursts, elation, suicidal behavior or curious mannerisms. In brief, all Italian patients had so much affective coloring, aimed primarily at male figures and images, that the paranoid schizophrenic label seemed to fit them poorly.

A second primary difference in the samples (Variable B) dealt with the central tendencies in each culture for channeling emotional expression. To some extent, this expression of the emotional life in each ethnic group applied also to female patients. Italian culture generally sanctions the freer expression of emotions than does Irish culture, and emotion may be expressed, in lower class groups particularly, in bodily action. The Irish, on the contrary, are famous for a greater constriction of activity; and their most endearing trait, which no doubt compensates for this constriction, is an equally rich fantasy life. In Freudian theory, fantasy may substitute, almost vicariously, for action. The writer has, indeed,

already noted the intensity of emotion and its expression in activity in poorly controlled Italian patients. The counterpart in the Irish sample of patients was a fantasy substitute for action. While Italian patients might oscillate between hyperactivity and underactivity, or show an inability to time their activities, thoughts or emotions effectively, the Irish, with no such difficulties in timing or guarding their emotions, showed an inversely large proportion of rich and extensive fantasy. Their more deeply repressed conflicts consequently took a more delusional and paranoid form. One Irishman, for example, gave for two years a most lurid series of accounts of the death of each family member, blaming his mother for a horrible accident which befell the father. (The father had actually died at a ripe old age, in a hospital, of a common ailment.) With each monotonous recital, the father's death in front of the home became more blood-stained and painful. The mother became a cold, emotionless and witch-like figure described in an affectless tone and cursed as if in ritualistic magic.

Linked with these two primary variables of family authority structure and the channeling of emotional expression, were other cultural variables affecting the emotional life. With Italian males, more direct feelings of hostility flooded up from shallowly repressed levels, connected with feelings of being repelled by a father, older brother or surrogate authority figure. As concerns sexual identification (Variable 1 of the table), two-thirds of the Italian sample showed active homosexuality which had at one time or another been overtly practised. This rejection of male identity and strong repulsion from the male role fitted the variables already considered—hatred of the father, lack of stability in the mother, and the cultural sanctions for expression of emotion. Impulsiveness, acting out, and emotional overflow might be expected among the ill of this cultural group. This acting-out of impulse was often noted in a background of sociopathic escapades—common in childhood or in youth.

For the same variables, the Irish male patient, beset with anxiety and fear of female figures early in life, likewise lacked possibilities of a firm male identification, but here the fear was centered on the opposite sex; and the sexual repression and the emphases of the culture on sin or guilt made for a repressive, latent form of homosexuality. Instead of the open refusal to be male, or repulsion from the male role as in Italian patients (non-identi-

fication in Italians), the Irish had a fearful or anxious lack of positive male identification. Here the latent homosexual tendency was controlled by added distortions and repressions. If repressed sufficiently, the Irish patient was pallidly asexual. Only three, as the table indicates, managed to achieve or maintain the asexual balance in repression. In the 27 who were latent homosexuals, the distortions of body image had already occurred in several who had bizarre delusional misidentifications as to their sexual characteristics. One such delusional form may serve to illustrate: the patient who believed his entirely bodily structure in the front was covered by an "apron." This apron had certain feminine characteristics, like periodic bleeding or the capacity to distract the patient's thoughts ("affecting my thoughts"—adversely of course).

Beyond family structure, the problem of sexual identification, and the channels for emotional expression in each culture, lies a further series of the consequences of emotional stress and its pitfalls in poorly organized families. The sexual misidentifications (in Irish males) and non-identifications (or refusals to identify properly in the Italian series) are contrasting types which occur in very different defensive emotional structures. In this sense, Variables 2 and 3 of the table may be considered concomitant variations, or further consequences, of the basic themes of stress problems and affective controls in family structure. Obviously, personality traits exist and function together in the total business of living. Thus the concepts of sin and guilt, particularly in the sexual area, were built up in the Irish patients and were readily accessible in their cultural stock-in-trade. Not only did 28 Irish patients torment and exacerbate themselves with such sin and guilt formulae, but 21 Italians of similar faith did not apply the irritations of sin and guilt to their sexual ideologies. Again, with the Irish, such formulae often become delusional and persecutory. A particular kind of mythology, prominent among nonliterate peoples, and concerning a toothed, castrating vagina occurred in the setting of incestuous guilt about feelings toward sisters and other female relatives in several Irish cases. Contrary to this, 26 Irish patients showed no evidence in the hospital or in life histories of ever having been involved in any sociopathic behavior, whereas 23 Italians showed repeated and marked evidence of behavior disorders. As has been seen, the attitude toward authority (Variable 4 of the table), more consciously expressed in instru-

ments like the Sentence Completion List, or exemplified in life histories and ward behavior, indicated a similar difference in attitude, with 24 compliant Irish patients to almost the same number of more rebellious Italians.

Variable 5 of the table explored the prediction that the Irish patients, with their anxious fantasies, their latent and repressed homosexual trends, and their indoctrinated "sex-is-sin" feelings of guilt, would be forced to build fixed delusional systems. While Irish patients used delusional or fantasy defense against their sexual misidentification problems and shattered self-esteem, the Italians expressed their sense of defeat and hostility mainly in mood swings, excitements and impulsive behavior. Thus delusional fixity occurred in a ratio greater than three to one for the Irish, while exactly two-thirds of the Italian patients had no manifest delusions during the study and half of the remaining 10 had changeable and minor delusional episodes. On the other hand, as might be expected, the Italian patients distinctly led in Variable 6 of the table, in the frequency with which hypochondriacal complaints about imagined somatic disorders were mentioned. For Variable 7, only one of the Italian patients had ever been chronically addicted to alcohol although all liked wines, whisky or beer. In the Irish, on the contrary, almost two-thirds had sought escape from problems in protracted periods of alcohol addiction.

In discussing this relationship between environment and mental illnesses, authors like Stanton and Schwartz in their book, *The Mental Hospital*, or Fromm-Reichmann in her *Principles of Intensive Psychotherapy*, have discussed patients' reactions to ways of handling them, to interaction processes on the ward, or to different psychotherapeutic approaches. These authors concede a general validity to the idea that no patients, not even schizophrenics, live in a cultural vacuum. But the related thought that the course of illness and the very structuring of personality bear a cultural imprint is neglected in the literature. All nine variables discussed so far show inner consistency and integration of defenses which constitute two separate kinds of illness for the two ethnic groups. Psychiatrists, in treating each type, can be more effective if they understand these linkages of culture and personality. What Sullivan called "the schizophrenic way of life" can be related and re-geared to more positive cultural determinants only after one understands the differences in family struc-

tures, in self-identification problems, and in methods of emotional control which have made up the characteristic blend in any balance of defenses.

A final, or tenth variable (Variable C) was therefore used in the study to describe this balance of defenses. It was found to favor fantasy and withdrawal patterns for the Irish to the extent of paranoid reactions. The Italian patients suffered from disorders of poor emotional and impulse control. The Irish were most anxious in their relations with persons of the opposite sex and the shaping of the basic personality contained notions of male inadequacy, fear of females and latent homosexual tendencies, intensified by sin and guilt preoccupation. With the Irish, self-esteem and identification were destroyed at the same time; and weakness, inadequacy feelings, suspiciousness and paranoid delusions took over. Hence bodily somatizations and hypochondriacal complaints, common in Italians, were rare in the Irish. Delusions became fixed in paranoid channels, and fantasy and distortion were used to preserve the delusional system intact. These were quiet anxious men, fearful of anything which might separate them from the protection of the ward and their well-regulated delusional systems.

Obviously, the Italian patients were different not only on each count, but in the total pattern of symptoms. As different, they represented other problems in management and therapy. A family structure, diametrically different from the Irish, favored overt expression of homosexuality. The different cultural emphasis on emotional expression led to the acting out of impulse. The strength of anger in this emotional lability, the motor excitements or flaring up of affect could throw the patient into confusional affective states, or into the excitements, periodic and sometimes destructive, which characterized an even greater proportion. This balance, or typical resolution of defenses, was most important in the actual handling and maintenance of rapport with each patient.

Cannon, Wolff, Funkenstein and others have each written on the physiological consequences of such long-standing emotional states. Possibly the attack on these problems will benefit from further psychological understanding. Important in the psychotherapy which accompanies and vitalizes such methods will be the joint contribution, no doubt, of psychiatry and anthropology. The former is expert in the guidance of the individual case, and

the latter is helpful in indicating the types of family organization and social experience which influence all behavior, normative or pathological. Future research in social psychiatry is now required on various mental disorders, and it is hoped that further explorations of this type will be carried out elsewhere.

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TREATMENT AND MANAGEMENT OF CHRONIC PSYCHOTIC PATIENTS IN A GENERAL MEDICAL HOSPITAL*

A Three-and-a-Half-Year Experience

BY IAN C. FUNK, M.D.

There has been increasing concern in the past few years over the problem of the aged, over the increase in age of mental patients, and over the crowded conditions in Veterans Administration and state hospitals.

A pilot study was proposed by the Veterans Administration to determine the feasibility and merit of transferring a fairly large number of long-term psychotic patients, some with physical and surgical disabilities, to newly-opened general medical and surgical Veterans Administration hospitals. The pilot study known as "The Albany Plan" was begun on August 21, 1952 with a fairly large number of transfers. Most of the patients who were transferred early had concurrent medical or surgical disabilities to varying degrees; some were bed patients, others were wheelchair patients, and some were ambulatory. A total of 351 such patients was transferred to the Albany Veterans Administration Hospital, most of them during 1952 and 1953; and there have been additional transfers since that time.

The philosophy behind this plan is basically sound and has psychiatric merits. First of all, it is common knowledge that the largest load in all Veterans Administration hospitals is that of the psychiatric patients; and, of this, the largest load is made up of long-term patients. The idea of transferring a fairly large number of long-term psychotic patients, not to a mental hospital, but to a newly-opened general hospital, with new methods, and new personnel, certainly appears very attractive. At times, a long-term psychotic patient will improve without any other apparent reason except his transfer to another hospital.

The Albany Veterans Administration Hospital is a 1,000-bed, general medical and surgical hospital. It has about 17 acres of land, situated within the city limits near the Albany Medical College Hospital. The psychiatric service is situated on the ninth and tenth floors, with a 340-bed capacity. The patients received were from the larger Veterans Administration neuropsychiatric

*From the Albany Veterans Administration Hospital and Albany Medical College.

hospitals, where large grounds were available. These patients had been hospitalized, for the most part, for 20 to 30 years. Some of the more recent transfers had been hospitalized from five to 10 years. The patients in general were between 50 and 60 years old; two-thirds had functional psychoses and one-third organic psychoses, most of them being markedly regressed. Most of the patients had been on locked wards in their old hospitals.

The statistical picture, as of the survey made July 1, 1956, follows: Out of 351 patients transferred to this hospital, 235 remained in the hospital, 55 had died; 15 had had to be transferred back because they were not suitable; three had been transferred temporarily to a Veterans Administration hospital where facilities for treating pulmonary tuberculosis were available; three had been transferred to Bath Domiciliary Home. Twenty-four patients had been discharged from trial visit, 16 were on trial visit. All patients were on open wards except 28 who were on the infirmary ward which is attached to the medical service. One hundred ninety-seven patients were on the ninth floor which has no security windows or doors and 50 per cent of these patients were privileged. Practically all the patients on the ninth floor ate in a "general medical and surgical" dining room on the third floor. Approximately 20 patients from the ninth floor and 15 from the tenth floor were on passes to town, on their own for the day.

One might think that the presence of so many chronic psychotic patients in a general medical and surgical hospital would create innumerable difficulties. However, partly because of the attitude shown by everyone in the hospital, and partly because it was a new hospital, very few real difficulties were encountered. The psychiatric patients were gradually well accepted by the rest of the hospital and by the nonpsychiatric patients. There is no doubt that these transferred patients were given more freedom, more privileges and more responsibilities than they had had before.

Generally, the psychiatric patients' attitude toward the hospital is a friendly one, and the personnel in the hospital have been friendly toward the patients. The attitude of the personnel in the ancillary services—such as special services, dietetics, the registrar division, etc.—undoubtedly has helped to create an acceptance of these patients. The attitude of the psychiatric personnel, psychologists, psychiatrist, nurses and aides, was never a rejecting one; and, actually, a hopeful atmosphere maintained itself

throughout the three years of this study; and in view of the later results this attitude has even improved.

Many changes occurred on the psychiatric service during the period of study. For the most part, these changes were a matter of expediency; on the other hand, it has been the writer's feeling that rehabilitative procedures should never remain static in terms of the management of the long-term patient. Unless changes are made from time to time, in terms of management or in terms of activities, there is no progress. Even worse than this, the patient becomes so set in his habits, because of hospital rules or management, that the activity in itself is no longer beneficial.

Gradually, the writer became convinced that changes were not only therapeutic but were the only modality of treatment that affected the chronic patient. Change became the central theme of the treatment program and exerted an influence on every aspect of the patients' daily life. As the writer sees it, the management of the chronic patient is somewhat different from that of an acute patient where stability of the environment is most important.

When the acute psychiatric service was opened in July 1953, certain chronic patients were moved from the locked ward to the new admission service for treatment. Even though these patients were in the older age group and had a number of medical and surgical conditions which would usually contraindicate electric shock treatment, it was possible to give electric shock with a fair degree of safety, using anectine, and moving them from a locked ward to an open ward, where most of the time a favorable change was noted. It is important to place these patients on an open ward because they come in contact with more normal people more of the time, and this affects them beneficially. Too frequently, chronic psychiatric patients are placed in a building or ward rather far removed from the main traffic of the hospital, where they seldom come in contact with more normal patients or normal people, but spend most of their time with patients who are like themselves.

Several experimental approaches were tried with the long-term patients. Early in 1953 an experimental approach of a "total push" type was tried on 10 chronic patients with 10 controls.* In this study, which lasted for 26 weeks, three out of 10 of the experimental-group patients showed marked improvement, three patients

*See: Funk et al. in bibliography.

moderate improvement; in four there was no marked change. Later on, neurotic patients, patients with character disorders, and some schizophrenics, recovered from acute episodes, lived together on the same ward with the chronic patients. This project was followed through for about six months, and here again favorable results were noted. At the time of writing, about 15 chronic patients are living on another open, patient-government ward, with schizophrenics recovered from acute attacks, neurotics, and patients with character disorders; and favorable results are noted here also. These chronic patients all go on passes to town by themselves, have week-end passes and participate in the ward responsibilities. These trials have shown that chronic patients can be stimulated to behave and act more normally when they are expected to do so.

If chronic patients failed to improve through this kind of management and activities on an open ward, active treatments were started. Since 1954, reserpine and thorazine have been used singly or in combination, occasionally preceded by five or six electric shock treatments. It is important to stress two points. First of all, the patients treated were not the ones who usually receive treatment in a hospital. They were chronic patients, very regressed and usually causing no trouble on the ward. Second, the attitude of the personnel toward treatment changed. While previously the patient was managed permissively, an attitude of firmness was now assumed on the part of all. This would somehow communicate to the patient that a change was being made and that a change of behavior was expected in him. Usually the patient would then be transferred to the acute treatment ward, as if he were a newly admitted patient.

These patients were placed on various activity programs, under the physical medicine rehabilitation service and under special services. An effort was made to rotate the patients in the existing facilities as the limited number of personnel would not allow large numbers of patients to be placed in any one activity. As a general rule, about 32 patients are on corrective therapy, 42 in occupational therapy and 50 in industrial therapy at any one time. The patients are regularly taken on bus trips for rides or to shows in town. These activities have played a very important part in the treatment program.

In terms of long-term psychiatric patients, some of the things that appear to be important regarding activities are: First, the patient must go to the activity; second, the activity itself must change; and, third, the activity must be of a type in which the patient cannot avoid being involved with other people. Many long-term patients passively go to most activities but often don't derive much benefit from them. The reason for this is that the patient does not actually involve himself in the activity, just passively co-operates. For instance, although the patients go regularly to the canteen, some order too many things to eat, others just sit down and wait to receive something. If they are allowed to continue this behavior, week after week, and month after month, there is no doubt that not much benefit would be obtained; they would not develop initiative. For this reason, the nursing personnel were instructed not to assist patients in their purchases or to wait on them. As a result of this change, patient J.H.B., for example, after having passively remained seated for three months during canteen visits, one day got up and asked for an ice cream soda and paid for it. Chronic patients have well-established patterns of behavior. If the personnel members continue in their own unchanged pattern of behavior, most of the time taking the line of least resistence, this, perhaps, explains the chronicity of mental illness as it has been seen. Too often the hospital considers a patient co-operative if he adjusts to the hospital situation. However, for the long-term patient this should not be the goal, and any evidence of initiative, though it might be considered un-co-operative on the part of the patient, should be encouraged rather than discouraged.

The most useful treatment program for the long-term patient appears to be one in which the patient is involved with other people. Any activity program which increases the contact of the patient with normal people appears to be therapeutic. For this reason, industrial therapy, which places the patient in contact with hospital personnel in their daily work, is beneficial. Dances with volunteers have shown the same encouraging results. Certain group activities, such as group therapy, music therapy and certain types of recreation, where the patient comes in contact with outside people and with volunteers, are also very useful.

In reality, what is one trying to rehabilitate them from? Is it the mental illnesses that they had 15 or 20 or 30 years ago, or is

it from being in the hospital for that length of time? A patient who has been in a hospital for a number of years takes on a certain appearance. He appears to be what is usually described as "apathetic and regressed." What causes this? One might speculate that the long years of hospitalization are at least partly, if not totally, responsible. If a patient is locked up, or even if he is not locked up but is taken care of for years and years, he loses initiative. The rehabilitation should center around helping the patient to help himself and not just doing everything for him. Often times this runs somewhat against the grain of the personnel, such as nurses and aides, who feel that they ought to do more for the patient. For example, there is a morning coffee time on the neuropsychiatric service, a period which serves as a medium for mixing the patients and the personnel. It was noted by one of the members of the staff that the aide was pouring the coffee, putting in the sugar and cream, and serving the patients. Such a "helpful" attitude only reinforces the patient's helplessness and is, therefore, not therapeutic; it would be preferable if coffee were delivered to the dayroom and the patients helped themselves or helped one another.

The most difficult rehabilitative program in the hospital is one that stresses the necessity for the patient to assume responsibility even in a small way. This type of rehabilitation conflicts with what the hospital usually stands for, since a hospital has an opposite mission, that of reducing responsibilities. In the long-term patient, however, it is essential that initiative and responsibility be assumed to some extent by the patient. These goals require constant training of personnel, actually a re-learning process. Just recently, on the neuropsychiatric service, another little step was made in this direction. It came to the staff's attention that patients were receiving services and articles without taking initiative to obtain them and without their full knowledge of what getting them entailed. This was true in the case of their receiving newspapers, shoe-shines and haircuts. As this was a very "unreal" situation, patients were given canteen books even though they were nonprivileged, and, thereby, were given the responsibility to decide for themselves whether they wanted these things. (Incidently, it was found that the chronic schizophrenics were extremely miserly; instead of paying for shoe-shines, for instance, they decided to do the job themselves.) To further the patient's

responsibility for making free decisions, a beverage dispenser was placed on one of the wards, and patients received approximately a dollar, in different denominations of small change, weekly. This is done in a business-like manner: The patient, standing in line, gives his name and signs for his money.

The attempt has been to achieve two goals: first, to prevent the newly admitted patient, whether in acute or chronic stage, from staying in the hospital too long; second, to try to undo the regression in the long-term patient. With these aims, changes on the service proper have been made from time to time. Just recently the five chronic wards were combined into two wards in a community-living plan.

One group, comprising 97 patients, was assigned a living room area with a separate sleeping room area. On another ward, 101 patients had the same arrangement. This change allowed for larger living room area, not just one room but five different living rooms, furnished with lamps, hassocks, card tables, etc., to provide a nonhospital atmosphere. This arrangement permitted a higher concentration of personnel per ward. Two doctors, one psychologist, a full-time nurse, one secretary and four aides comprise the team on each ward, and this enables the patients to get more attention than previously, when they were distributed over five wards. While previously, time and distance prevented communication between personnel, now a ward meeting of all personnel takes place daily, and there is a free exchange of ideas and individual-patient problems.

Some patients reacted to the change in living arrangement by complaints and resentment. This is actually helpful to them, the evidence of complaining being taken as favorable prognostically. Also this change had a very good effect upon the personnel, especially on the psychologists and nurses, who respond with enthusiasm. One might think that having chronic psychotics on an open ward would increase the problem of elopement. This has not been so, since very few elopements have occurred. When one has occurred, the patient has been returned, and nothing more has been done about it except to have an interview with him. Often in hospitals, whenever an elopement occurs, the patient is returned to a locked ward, and, therefore, the little initiative he has shown is stopped. Rehabilitation is nowadays more frequently equated with work outside the hospital. In most of the writer's cases,

work on the outside has not been a realistic goal. The patients have lost contact with their families, and apathy and regression have occurred. However, the chronic patient can be retained to become a better hospital citizen if given more freedom and more responsibilities. The progress is very slow; it takes six months at least to see any change, and perhaps three or four years to notice really marked improvement.

However, after three-and-a-half years of this study more and more marked changes began to be seen. As mentioned before, an increasing number of patients were on a ward without supervision, went to town alone on passes, and were becoming more interested in working on the outside. To help them in this work adjustment, three patients were placed on a member-employee program in this hospital, and some went on a night hospital schedule, that is, they lived in the hospital at night, going to work during the day.

Another point to stress is that there was considerable change in the psychiatric staff's attitude which could be summed up more or less as an increasing amount of confidence in managing the freedom of the chronic patients. At first, it would have been inconceivable to think of one of these patients going out on pass on his own. But it became a regular routine, as long as certain criteria were met.

The general criterion for increased freedom is that the patient has changed following management and treatment. At this point, the patient is given more and more incentive for further changes. He is given increasing privileges, of all types, such as wearing his own clothing, setting his own rules, going to bed when he wishes, and leaving the hospital on a pass when he wishes to. He is given a pass then, not because he has to satisfy the ward doctor that he has a perfectly valid reason, but because he is a trusted individual, who can make up his own mind and who can have enjoyment just for the sake of providing pleasure. By this type of management, the patient's self-esteem is raised. It then becomes apparent to him that there is an advantage in not being a patient any longer. This heightens his self-respect and he makes plans to leave.

In conclusion, it might be stated that to undo the regression and apathy of the chronic mental patient, a general medical hospital appears to be a very satisfactory place. Perhaps its only drawback is that it is still a hospital with all that it entails. One

might propose or suggest to the many general medical hospitals the challenging problem of the chronic mental patient. At the onset of this program, the hospitals were overcrowded and could not take care of all the acute psychiatric patients satisfactorily. However, the picture has changed; with the new drugs, the acute patient leaves the hospital sooner. The idea of integrating some long-term psychiatric patients on the acute psychiatric service and giving them the benefit of the new psychiatric treatments and management appears to be a very worth-while challenge which can be a gratifying one.

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CREATIVITY AND MENTAL ILLNESS

A Study of 60 Creative Patients Who Needed Hospitalization

BY PHILIP S. HERBERT, JR., M.D.

Introduction

Although creative persons have developed mental illnesses, and in recent times a number of them have sought psychiatric help, there is a striking lack of specific documentation of their illnesses and therapy in the psychiatric literature. Lee[1] asserts, in a critical review of this literature, that most of it is speculation, questionably grounded in clinical experience, much of it elaborating on Freud's original observations and formulations,[2-4] but failing to come to grips with the specific problems of individual artists observed and treated by the writers themselves.

There is abundant literature, mostly psychoanalytic, concerning artists as studied through their productions and through their biographies, of which Freud's *Leonardo da Vinci*[3] is a classic example. Lee suggests many shortcomings of this method of study.

Isolated case reports, such as those by Boyer,[5] Hedenberg,[6] Kris,[7] Lowenfeld,[8] and others provide interesting but somewhat fragmentary information, collected by a variety of techniques and interpreted from widely divergent viewpoints.

Bergler[9] and Lee[1] have had considerable experience with creative persons, whom they have studied and treated psychoanalytically, but they have arrived at rather divergent conclusions as to the specific personalities, conflicts, and illnesses of their patients. This may be due in part to differences in their case material. The patients reported by Bergler seem to have been mostly writers suffering from alcoholism or homosexual conflicts, while the patients reported by Lee (mainly artists, writers and, apparently, scientists who do original, creative work) seem to have suffered from reactive depressions.

Still another group will be described in this paper: creative persons who became so incapacitated by a variety of mental illnesses that they needed treatment in a mental hospital.

Selection of Patients and Method of Study

The records for the years 1928 to 1955 of the patients who, on admission to The New York Hospital—Westchester Division,

gave as their occupations "writer," "artist," "composer," "commercial artist," etc. were collected. There were 92 such charts. These records were then studied in an attempt to evaluate the importance of creativity in each patient's total life adjustment. It became apparent quickly that creativeness in terms of accomplishment was minor indeed in over one-third of this group. These 32 patients included those who had shown little or no evidence of real talent or motivation toward the arts, whose ambitions seemed to be almost completely on an autistic level, or who seemed to be using creative activity as a "cover" for an aimless, Bohemian, or parasitically dependent adjustment, with no evidence of productivity. The remaining 60, who are the subjects of this paper, varied in their achievements but had gained some degree of commercial or critical success. It was difficult to set up precise criteria, but the publication of a book, the exhibition of paintings, the winning of awards, prizes, or critical acclaim—one or more of these—was felt to be adequate evidence of the genuineness of creative capacities. Some of the patients had used their talents in fields closely allied to original, creative painting, writing, and composing—others in fields of designing, teaching art, journalism, and so forth. Many of these latter, however, had shown minor or unsustained originality.

The 60 selected records were studied and abstracted, with particular attention focused on the family background (especially for evidences of creative tendencies or instability in other members of the family), emotional development, accomplishments outside of the creative field, life situation at the time of illness, apparent precipitating factors, unusual features of symptomatology, course, and outcome. Particular attention was paid to data that might suggest or tend to rule out possible relationships between the creative capacity and emotional illness. To this end, an attempt was made to assess three variables: (1.) the patient's productivity in his creative work (in most instances, only the roughest and most tentative judgments of "quality" could be made, if they could be made at all, but it was usually clear as to whether he was or was not producing); (2.) his ability to function effectively in other areas of life, relationships with others, noncreative jobs, etc.; and (3.) the absence or presence—and severity—of symptoms of emotional illness, as all these variables changed, and were inter-related, throughout his life history.

Findings

Description of the Group

Thirty-two of the 60 patients were men and 28 were women. There were 26 artists (painters, sculptors, designers, etc.), 32 writers, and one composer. The ages on admission ranged from 21 to 90; but only a quarter of the group were over 50. This series is too small to allow for statistically significant comparisons between the different decades of life within the group, or with the age distribution of other patients in the hospital, but it is noteworthy that more patients were hospitalized in their 40's than in any other decade (18 out of 60, or 30 per cent). Only a little over half of the patients (31) were married at the time of admission, 19 were single, 10 had been divorced or separated, and two were widowed. Subsequent to hospitalization, at least seven of the marriages terminated in divorce; thus, there were only 24 lasting marriages in the group, plus two that had been terminated by death. Six of the patients were foreign-born, the rest coming from a wide variety of American backgrounds.

Diagnoses

Diagnostically the patients were classified as follows:

Diagnoses	No.	Per cent
Personality Disorders		
Psychopathic personality: (with psychosis) ...	3	5
Psychopathic personality: (without psychosis, includes sexual deviates)	2	3.3
Addiction: Alcohol and drugs (includes those with toxic-organic reactions secondary to alcohol or drugs)	11	18
Total Personality Disorders	16	27
Psychoneuroses	5	8.3
Schizophrenia	18	30
Paranoid condition	2	3.3
Manic-depressive psychosis	12	20
Involutional melancholia	4	6.7
Organic mental reactions (excluding toxic-organic reactions to alcohol or drugs)	3	5
Total	60	100

These percentages correspond rather closely to the percentages of illnesses in all other patients admitted during the same period, with the exception of the 18 per cent admitted because of addiction

to alcohol or drugs, which is probably significantly higher than in the general hospital population. There was no significant difference between artists and writers, though there was a somewhat higher percentage of psychoneuroses and a somewhat lower percentage of personality disorders among artists as compared to writers.

It had been this author's original impression that the illnesses of gifted or otherwise unusual patients were likely to differ in symptomatology—especially in the formulation and elaboration of delusional trends—from the illnesses of the non-gifted or "average" hospital population. However, careful study of the descriptions of the patients' symptomatology, especially of their behavior in the hospital during the acute phases of their illnesses and convalescence or chronicity, showed little difference from the "average." An observer who did not know these patients' occupations, and who did not observe them at work at their occupations in the hospital, would have had no clue that they were in any way different from the others—with the exception of three patients in the series.

One schizophrenic poet manifested a most fancifully elaborated delusional trend, with much striking and colorful imagery, during the first few months of her illness; later, with a downhill course, this trend became banal, colorless, and poor in imagery. A schizophrenic painter, early in her illness, believed herself to be in communication with Rembrandt, Vermeer, and Bellows. The one composer, in the course of a manic episode, had an expansive, ecstatic trend in which he was identified with Christ and, in addition, was the medium through which forces outside himself had produced masterpieces of poetry, fiction, and music. (It is perhaps important that this patient's creativeness had suffered a slow decline over a period of many years.) His trend was also outstanding for its rich, elaborate imagery.

Mental Illness and Creativity in Family Histories

Analysis of the family histories of these patients revealed two striking findings. There was a high incidence of mental illness or maladjustment in the families, but a very low incidence of creativity. Among these patients, 20 per cent had had a psychotic parent or sibling, 40 per cent had had a parent or sibling who was markedly maladjusted or severely psychoneurotic. Of the re-

mainder, most of the patients had family histories with a high incidence of marked eccentricities or mild, well-compensated psychoneuroses. Only three patients had family backgrounds that were stable and happy.

If these families were rich in "tainting," they were poor in creativity. Only 13 of the patients had near relatives who were talented or even moderately interested in the arts, and in six of these instances, there was no more than a minor talent or a mild interest. The other seven patients of this group each had a parent or sibling who had made outstanding contributions in the same creative field as the patient, and in four instances had far surpassed the patients.

Personality Development of the Creative Patient

In the great majority of cases, there was a history of obviously disturbed relationships with parents and clearcut evidence of maladjustment in childhood. These relationships were not always traced out in all their complexities, but patterns of rejection, smothering possessiveness, overprotection, exploitation, subtle or frank seductiveness, or combinations of these were apparent in most histories. It was difficult in some instances to determine how far the parent-child relation was weighted toward pathology, but the clearly unhealthy family settings far outnumbered the clearly healthy ones. In no more than six cases, were the relationships with parents and siblings close, affectionate, and unambivalent. As children, many of the patients had felt isolated and lonely, and in their outward behavior they were demanding, aggressive, or rebellious. A few showed overt neurotic symptomatology, such as phobias. There seemed to be a positive relation between effectiveness in creativity in adult life and predominantly happy and secure childhood. Ten patients in the series had sustained their creativity in original work for a decade or longer, and five of these had had happy and secure childhoods. The other five had been unhappy and maladjusted. However, in the rest of the group, there was only one patient who had been predominantly happy and secure as a child, and his artistic career, though brief, had been a distinguished one.

Adult adjustment did not seem to be much happier for most of the patients. During their adult lives most of them showed unmistakable evidence of marked emotional immaturity or emotional conflict in one or more of the following respects: selfish, exploiting-

relationships with others, excessive dependency, inappropriate hostilities poorly handled, and sexual maladjustment. Only a few of them had made stable marriages and had warm, unambivalent relationships with spouses, children and friends. Only about half of them were consistent, diligent, and self-disciplined in their approach to their work. This group included the 10 previously mentioned who had sustained a high level of creativity for over a decade. The case histories which will follow will illustrate some of the difficulties these patients had with love, sexuality, responsibility, and self-direction.

On first studying the case material, it was this author's impression, that creativity appeared possibly to have been a stabilizing factor in the lives of most of these patients. In some, it seemed that it was their only satisfying and realistically rewarding pursuit; that besides a livelihood it gave them a sense of direction and meaning in their lives, and that it was of some protection against mental illness. However, closer examination of the data and careful consideration of their implications left this hypothesis highly conjectural. It could neither be proved nor disproved, although the weight of the evidence seemed to be in its favor.

In some 16 patients, there seemed to be some relation between a failure in creativity and the onset of an illness. This failure might be a lack of acceptance by others; failure to reach a high and perhaps unrealistic standard; recognition that the latest work was inferior to previous works; or, again, fear that creative ability had declined, or recognition of such decline. However, a specific causal relation could not be safely postulated. Two patients, who had depressions in the setting of creative failure, had subsequent depressions associated with disappointments which had no relation to creative failure. In three others, the creative failure seems, more probably, to have been a symptom, than an important cause, of the development of the illness. In the other cases, the relationship seemed even less clear. Sometimes there seemed to be several precipitating factors in the illness, as in one artist in whom mild organic mental changes, diminution of sexual potency, and some impairment of creativity, perhaps secondary to the organic mental changes, all seemed important in the genesis of the disorder. In no instance, could creative failure be incriminated as the sole, significant, specific cause of a mental illness. Indeed, in all 16

cases, there were other, severe difficulties in the life situation which might have had more causal significance.

The most usual precipitating factor in the mental illnesses of these patients seemed to be the frustration of excessive dependency needs for love, help, or guidance. Less commonly, there was an exacerbation of a severe, unresolved sexual conflict.

One particularly striking finding of this study should be mentioned, before proceeding to the specific case material. This is the remarkable preservation of the creative capacity in the presence of severe symptoms, whether neurotic or psychotic. This was particularly marked in the group which had maintained a high level of creativity over a period of many years. About a quarter of the patients in the series were able to maintain their creativity after they had become incapacitated in almost every other respect. It appeared, however, that the more severe the illness, regardless of type, the more likely was the creativity to be lost. In almost every instance in which it was lost, however, it began to return with the recovery from symptoms; indeed, some manifestation of creativeness was often one of the first signs of improvement. In almost every instance, recovery from symptoms was accompanied by the full return of creative ability.

Illustrative Case Material

Case 1

Mr. A., a 26-year-old single artist, was admitted to the hospital after a suicide attempt.

Of Scotch-Irish extraction, he was the youngest of five sons of an erratic and restless father and a possessive and somewhat domineering mother, toward whom, as an adult, he felt bitter hatred. At first a "happy-go-lucky" child, he had become shy, retiring, and inarticulate by the time he reached school age. Though not seeming to be close to the family, he got along well with his older brothers. Theirs was a lonely life in a rural community. A prominent American painter who lived nearby noticed and fostered the patient's artistic talents. In school he was shy and awkward, then rebellious. There was much anxiety about masturbation in adolescence, and he got into serious difficulties with the school because of his first heterosexual experience. At 16, he began to drink in sprees.

At 17, he went to New York to study art. This was at the beginning of the Depression, and his struggle to maintain himself and pay for his training through odd jobs was a heroic one. Spree drinking continued at rather infrequent intervals; but, when intoxicated, he would become pugnacious, then would seek sexual relations with prostitutes. He had several affairs with women for whom he had no affection. However, he made good progress in his training. A somewhat older couple made him their protégé, and he did very well with their help and encouragement. However, unexpectedly, the woman made a sexual overture toward him and he became acutely depressed, went on a long binge, and then made a suicidal gesture. When hospitalization was suggested, he sobered up, asked for a two-week period of grace, and worked effectively to finish a painting.

On admission to the hospital, he was observed to be self-absorbed, mildly depressed and preoccupied, self-conscious, and rather inarticulate. He expressed anxiety about homosexuality and a fear of losing his mind. During his hospital stay, he worked steadily and effectively at painting in occupational therapy, in spite of his fear of revealing himself in his pictures. He seemed to derive some relief after ventilating his fears and insecurities, but gained little insight in psychotherapy. He was discharged as much improved, and in the years since has achieved considerable distinction in painting. Erratic behavior and occasional drinking to excess have continued.

Comment. This case exemplifies several important characteristics of the patients in this series. A.'s childhood was more obviously unhappy than the childhood of many of the patients, and he combined the passively withdrawn, aggressively rebellious, and overtly neurotic reactions to growing up. In most other cases, only one of these was manifested. The difficulty and unhappiness of his relationship to his parents is less thoroughly documented than in many of these patients, but they were unmistakably present. Severe sexual conflict is strongly suggested by his extreme anxiety over masturbation, his preference for prostitutes and women he could not esteem, and his concern about homosexuality. His drinking habits and his relationship with his patrons might imply excessive dependency needs, but one should be cautious about making this inference in view of his realistic need for financial and emotional support at the start of his career.

The precipitating event of his illness seems to have come from a threat to this source of security, though it is more than possible that it re-activated a severe, unresolved Oedipal conflict. His continuing to work through a period of great unhappiness and upset is characteristic of the group, particularly of those artists who sustained a high level of creativeness, presumably through other vicissitudes, also.

Case 2

Mrs. B., 40-year-old housewife and artist, was admitted to the hospital in an agitated depression.

She came of German-Russian-Hebrew stock, in which there was no apparent instability. Her mother died when she was five, and thereafter she was raised by a strict paternal uncle and aunt. She was close to neither; and she became upset, some years later when a warm, apparently stable Christian couple, of whom she was fond, offered to adopt her. This marked the beginning of a conflict about religion which persisted into her adult life. She showed a marked ability in drawing and drafting, and at 18, on coming to the United States, began the formal study of art. She "worshiped" her teachers and did well.

After marrying a quiet, stable, protective man, she continued her career, with his approval and support, and attained commercial and artistic success with her portraits. She had two children and was outwardly a happy and devoted mother, but, when she became pregnant for the third time, she insisted on an abortion, stating that a third child would be too much of a burden. Aside from this, she seemed to be leading an entirely unremarkable and conventional life. She made many friends and became active in club life and community affairs. She felt somewhat uneasy about living in a predominantly Christian community, but this was not a major concern until she was reproached by some of her orthodox Jewish friends for her friendships with Christians. Thereupon, her religious concerns became exaggerated; and, after a period of perplexity, she became irritable, worried, restless, and depressed. Her menses stopped. She lost interest in her art, but successfully finished a portrait. She made first a suicidal gesture, then a serious suicide attempt, and was brought to the hospital in an agitated, perplexed, depressed, self-depreciatory and frankly suicidal state. She expressed many guilt feelings, particularly a feeling that she had neglected her children.

In the hospital, in spite of a moderately severe agitation and depression, she attempted to do art work, but could only copy—in her therapist's words—"in an amateurish, puerile" fashion. Her artistic endeavors became more effective as her symptoms abated, but she relapsed and became incapacitated for creative endeavor. Again, as she recovered from her symptoms, her creative effectiveness returned, and she maintained her health and creativity for many years thereafter.

Comment. This case presents some apparently unusual features. Stable, happy marriages were the exception, rather than the rule, in the series. Few of the patients had children, and even fewer had happy relationships with them. Few were actively sociable or had strong interests in, or ties to, their communities. However, even in this case, one sees elements of more typical behavior. It has been mentioned that these creative patients tended to lean heavily on others for love, support and guidance. A few, perhaps no more than a quarter of the total, found marital partners, relatives, lovers or friends who could fill these emotional needs. This patient was fortunate enough to find a husband who gave her affection and support. That her devotion to marriage and child-rearing was not wholehearted is indicated by her refusal to bear her third child. It was more typical of this group that motherhood was avoided or was the focus of obvious emotional conflict.

Some patients had frank, conscious fears of, or aversion to, pregnancy; others, though infertile and concerned about it, did not seek medical aid. In still others, emotional illness was apparently precipitated by pregnancy or the responsibilities of motherhood. Some seemed to have strong, underlying maternal attitudes and needs, but to deny them consciously. Mrs. B.'s apparently enthusiastic involvement in community affairs seems to have been built on a shaky foundation, but perhaps considering her generally adequate adjustment to another culture this insecurity might be within normal limits.

Case 3

Miss C., a 29-year-old art teacher, was admitted to the hospital in a mute and negativistic state.

She came of German Protestant stock, and was born in Europe, the illegitimate child of a presumably healthy and intelligent business man and a strong-willed, domineering, hypochondriacal, and promiscuous woman who made several attempts to abort herself

and abandoned the patient at birth. She was adopted and raised in the United States by an uncle and aunt who were devoted but strict and formal. She was described as a jealous but affectionate child; and she became a sensitive, impulsive, day-dreaming, moody adolescent and adult. Masturbation in childhood was accompanied by fantasies of being Joan of Arc. She was shocked at 15 to learn of her illegitimacy. Not long after, she became enamored of, and most dependent on, one of her woman teachers. She became almost inseparable from this woman, and may have had a homosexual relationship with her. She had a history of a few homosexual relationships, and a few inconclusive and upsetting heterosexual experiences which did not eventuate in intercourse. In the meantime, she had completed graduate work in art and had begun to teach art at a university. Although she was happy and effective as a teacher, her output of original work was small, and she spoke at times of a desire to paint on her own.

At the age of 29, while abroad, she became suddenly mute, resistive and incontinent. Regaining some contact, she expressed a wish to die. Brought back to this country for hospitalization, she again became mute, unresponsive and resistive. Over the next 14 years in the hospital, she had brief periods of improvement, but her over-all course was one of deterioration. For the first two years of hospitalization, while pursuing this fluctuating but downhill course, with periods of delusional, hallucinated, mannеristic, assaultive, and suicidal behavior, she produced paintings and drawings of considerable originality and merit, but thereafter her artistic productions deteriorated.

Comment. This patient, unlike the first two, was not primarily original in her creative work, though she showed a marked creative tendency which, for some reason, she was not able to develop as much as she wished. Its preservation for two years in the presence of a malignant, deteriorating illness suggests its strength. Her pre-psychotic history exemplifies and almost caricatures some typical difficulties in these patients, specifically in her sexual maladjustment and her intense dependency needs. She carried her dependence on her teacher—which may have found an overtly homosexual expression—to the point of accompanying her on her honeymoon.

Overt homosexuality was a comparatively infrequent finding in the series. There were only four patients who were confirmed

homosexuals, although it was probable that others had had some homosexual experiences. There was one patient who had a florid sadistic perversion. However, in others there was definite, though less striking, evidence of sexual maladjustment. If one accepts as evidence of maladjustment such problems as preference for devalued sexual partners, preference for oral-genital heterosexual relationships, preference for masturbation, intercourse without affection, extramarital affairs, marked promiscuity, anxiety about homosexuality, and frigidity, then only a few of the patients could be said to have reached a stable, mature level of sexual adjustment.

Discussion

When this study was first planned, the author hoped it might furnish evidence to support or refute the popular notion, which seems to be held also by some creative patients, that maladjustment is an essential condition for creativity. This study indicates that creativity is compatible with a high degree of maladjustment, but that the expression of this maladjustment in symptoms tends to impair creativity, confirming a well-accepted clinical impression. However, the data do not carry us much further than this.

An important reservation must be made about the patients in this series: As previously mentioned, they are a highly selected group, and trends which this group show are not necessarily typical of creative people in general. Roe's study[10] of 20 leading American artists suggests that some enjoy a fairly high degree of mental health, and that the artist may handle whatever emotional conflicts he does have very well. It might be interesting, and perhaps highly enlightening to compare the group reported on in this paper with a comparable, noncreative group, and also with a group of creative persons who have not needed hospitalization for a mental illness.

Summary and Conclusions

Sixty artistically creative patients admitted to the New York Hospital—Westchester Division, between 1928 and 1935 were studied.

1. The distribution of diagnoses within this group was comparable to the distribution of diagnoses within the general hospital population, with the exception of personality disorders—diagnosed as "psychopathic personality"—which were slightly more frequent,

and addiction, which was strikingly more frequent, than in the general hospital population.

2. Family histories revealed a high incidence of maladjustment, psychoneurosis, and psychosis among the parents and siblings of these patients, but little creativity.

3. In the great majority of cases there was evidence of obviously disturbed relationships with the parents, though there was no obvious common factor in all the cases.

4. There was frequently a history of loneliness or isolation in childhood, and the patients were generally timid and passive as children; a smaller number were aggressive, rebellious or demanding. Childhood neurotic traits were frequently found.

5. Those few patients who had happy, secure childhoods were most likely to have successful careers of sustained creativeness, though this type of childhood did not seem to be a necessary preparation for sustained creativity.

6. Outside of their work, and before their illnesses, most of these patients had had moderate to marked difficulties in adjusting to adult life. Typical conflicts seemed to center around inordinate dependency needs, sexual maladjustment, and inability to handle hostility well.

7. In no instance could failure of creative capacity be conclusively incriminated as the primary etiological factor in a mental illness. In most instances difficulties in the life situation which were not related to creativity seemed more important as causal or precipitating factors.

8. Creative capacity was frequently the last realistic, organized activity to be compromised by an illness, and on recovery, was likely to be the first to begin to return.

9. If the patient had been actively creative before his illness, recovery from symptoms was almost always accompanied by return of the creativity.

10. Three case histories were presented to illustrate these points and to exemplify and emphasize these patients' difficulties in adult adjustment.

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BECOMING AND BEING IN TIME AND SPACE*

BY EUGEN KAHN, M.D.

I

Time and Space are an entity. While one cannot take it apart, it is possible to focus on the Time-aspect or on the Space-aspect. It is conceived then that Time is always in a flux. In the flux of Time, everything *Becomes.*** Becoming means that everything that grows and develops, comes from some origin. Furthermore, Becoming means in the present context that everything originating and developing comes from the past and points into the future.

The human person in his situation is Becoming in the flux of Time. Person and situation are continually changing.† Whatever one may Become in the flux of Time, he goes forward from the past into the future. He can be considered as an entity, too—as an entity of Outside and Inside. The relation of the Outside-Inside-entity to Time and Space is a particular one.‡

To formulate: *Becoming*** belongs to and happens in Time. One adds: *Being*** belongs to and Is in Space. Space, with everything in it, contains the places in which we live and experience. Without Space—as without Time—we would be unable to live and to experience.

I *Become*** in Time, I *Am*** in Space. Time and Becoming would not make any sense unless there were "something" that Becomes in Time. Space and Time supplement each other. The "something" that Becomes in Time is the "something" that *Is*** in space. Space and Being without something would be as senseless as Time and Becoming without it. Only what has Become, can Be, and only what is going to Become will Be. Only something which has Become at some time can have Been. Whatever has Been had to Become before.

* From the Department of Psychiatry, Baylor University College of Medicine, Houston, Texas. Published in German in *Psychiatria et Neurologia*, 1959.

** "Becoming," "Being," etc. are capitalized in this discussion when they are used in the meaning given. When they are used as auxiliary verbs, they are written "become," "be," etc.

† To be exact, one ought to say: "the continually changing person in his continually changing situation." This is meant when the term, "person in situation," is used. It is used for the sake of brevity, for which reason, one also says "Time and Space" instead of "Time-aspect" and "Space-aspect."

‡ See p. 549 ff.

Becoming in Time and Being in Space are inseparable; one may call them "existentials" due to human and to other living creatures. The human individual enjoys the privilege of *experiencing* in Time and Space. Everything and everybody around him may exert impressions on him. He can refer (relate)* such impressions to former experiences. The experiencing person in situation gives a meaning to the present experience.** Sooner or later, he gives it an expression (in words or action or both).

I Become in Time, and I Am in Space. I experience in Time and Space. My experiences follow the formula, impression-reference-meaning-expression.† Quite a few experiences are never completed, that is, they are never expressed. Experiential contents are often identical with the impressions that start the experience. Many experiences refer to "objects" in Space which are seizable,‡ but there are thoughts, feelings, strivings which are experienced as impressions and contents, too. These phenomena can be taken over from other persons or produced by the experiencing individual.

Impressions or experiential contents taken over from others are interiorized into me. They come and take effect from the Outside; so do "seizable" objects. Impressions or experiential contents which I express go from my Inside into the Outside; they are exteriorized. There is not an absolute separation; for there is much I learned in my social-cultural milieu which I had interiorized, but which I now habitually exteriorize. In my childhood, for example, I have learned motives for the commission and for the omission of certain actions; these motives have become my own so completely that in my adulthood I rarely remember how I came to be led by one or the other of them. Yet the adult, too, is still affected from the Outside by many and manifold motives.

In experiencing, the emphasis may be changed from the Outside to the Inside or from the Inside to the Outside. If the change of emphasis goes from the Inside to the Outside, it appears to be

* The words refer and relate and the nouns reference and relation are used, respectively, with the same meaning. If relation between people is emphasized, the noun relationship may be used occasionally.

** The meaning is already an interpretation of the present experience.

† Called the experiential arc.

‡ Essentially, we "seize" objects in space with our senses, that is, we perceive them "through" our sensations.

connected with a turning toward Space. If the change of emphasis goes in the other direction, a certain turning away from Space and an increased turning toward Time seem to occur. In other words: Interiorization refers more to Time; exteriorization refers more to Space.*

Time and Space are "media" in which we experience.** The particular relations of Time to Inside and of Space to Outside are relative, since neither the Time-Space-entity nor the Inside-Outside-entity can be torn apart. Time-Space always remain Time-Space in whichever way I find my bearings through them in my experiencing.† Inside-Outside are so intimately connected that it is due to the standpoint and viewpoint of the experiencing individual where he wants to "separate" the Inside from the Outside.

As person in situation, I live and experience in *Time* in which I *Become* and in *Space* in which I *Am*. Becoming and Being in Time and Space can be called existence‡ if one cares to use this often misused word.*** As person in situation, I am in many relations "one" with my situation. I, as person in situation, comprehend my Inside and my Outside. My skin is not "the end" of myself, but I am a "piece" of my world. My Outside, although I live and experience in it, reaches in many ways into my Inside, while my Inside spreads in many ways into my Outside.

Since I Become without any respite, there is no standstill of Time for me as person in situation. I can Be only in Space. These observations lead to the paradoxical conclusion that there is in my world no temporal present for me as the experiencing indi-

* In this as in all such sketches it is impossible to conceive of and to present everything at once. Whether we underline Time and Space or Inside and Outside, we are always dealing with inseparable connections which scarcely can be made vivid enough in words; they would certainly become less understandable if we tried to say too much at once.

** This does not mean that all the contents of our experiencing have extension in Space.

† Time (clock time) can be measured only with spatial methods. Talking about Time we constantly use words and phrases which have spatial meaning, e.g., point of Time, span or stretch of Time. Time can be measured only when it has passed, that is, measured backward.

‡ The word "*Dasein*" is referred to Being and to Space. It is not identified with existence. It is obvious that everything which *is* "*da*" (there), must have Become somewhere, viz, "*da*" or somewhere else. (See p. 549.)

*** When used here it means the Becoming and Being of the human individual (person in situation) in Time and Space.

vidual.* My Being does not Become in Time, it Is in Space. Present means literally: being here in Space.** This is obvious in the Latin words *praesens* and *praesentia*. It appears odd that we lean, so to say, on our "Being here in Space," when we "go forward from the past into the future." The paradox of this thought, which is not new, disappears when we realize that I—a person in situation—cannot "get out" of either Time or Space. Hence it makes good sense to use the term Now when we deal with the present of experiencing.

II

We experience, as if it were, in two Times and in two Spaces. The world-Time is to be distinguished from *my* Time, and the world-Space, the universe, is to be distinguished from *my* Space. The relations are complex. My *Time* falls in with world-Time in so far as from my birth until my death a "stretch" of world-Time "passes." My *Space* can only be within world-Space. All my positions—all the spots or places I ever occupy—were there in the world-Space before me and will be there after me.

World-Time, objective Time, is measured with chronometers (clocks, watches); its quantitative divisibility and division are seen in the change from day to night, in the seasons, in the tides. We measure it with spatial measurements.† Analogously, we measure world-Space, rather *in* the world-Space, with conventional, "objective," spatial methods.

The span of Time during which I live and experience can be measured, like other spans of Time, only when it is over, that is, after my death. *My* Time and *my* Space, in and through which I live and experience, cannot be measured during my existence.‡ *My* Time and *my* Space can be "quantitatively grasped" in relation to world-Time and world-Space. *My* Time and *my* Space are a qualitative entity.

* One might interpret that I experience at present in a Time which does not exist. This interpretation cannot stand, because I am unable to exist without Time (timelessly). Pathological cases illustrate this fact impressively.

** Being here in Space—and nowhere else. One might think of the possibility that we try in the "present" to get some distance from Time, as its uninterrupted flux does not permit us somehow to catch our breath experientially. Time plays a remarkably small role in the present; one has indeed to construct a special mode of time lest it get lost.

† See p. 550, third footnote.

‡ It is, of course, always possible to determine the amount of Time through which I have lived and experienced, up to the present.

My Now-Here and my Inside-Outside and the exchange between my Inside and my Outside indicate that *my* Becoming and *my* Being occur only once; they render the qualitative character to *my* Time and to *my* Space. It is conceivable that life is somehow closer to world-Time and world-Space than experiencing, and that therefore it can be explained and measured in Biology and Physiology. In the Psychology of experiencing, such explanations and measurements are not available.

World-Time and world-Space are not only the "media" in which we live and experience, they can serve also as contents of our experiences. This is the case for the scientist and the artist as well as for the naïve, and even for the primitive, layman. The eternity of Time in which Becoming never ends, and the infiniteness of Space in which there is Being, are facing us with overwhelming magnitude. Thinkers and believers are exposed to the immense vigor of these experiences; they can be found in the foundations of a variety of *Weltanschauungen*. I, as a person in situation, experience these experiences Now-Here in *my* Time and in *my* Space.

My Time and *my* Space serve as experiential contents, too. I experience *my* Time, the Time in which I Become as *my* Time, often with particular emphasis as my Becoming, as the incessant change occurring within and with myself. I experience *my* Space, the Space in which I Am as *my* Space often with particular emphasis of my Being. This Becoming and this Being "move" us without interruption in our advancing development through all manner of places and positions toward that point in Time and Space at which our Becoming and our Being end. We experience countless Now-Heres before we die. It is in the Now-Here of my Becoming and of my Being, that I experience my existence.* From my Now-Here, I am able to look backward and forward; this means that I can "remember" as experiential content "Then-There" (a place where I Was in my past), and that I can "anticipate" future experience which I expect to have "Then-There" (a place where I expect to Be in my future). This trinity of Time, Augustinus has formulated in his simple, classical style: "There be three times; a present of things past, a present of things present, and a present of things future ... present of things past, memory; present of things present, sight; present of things future, expectation."

* See p. 550, fourth and fifth footnotes.

It was indicated that *my* Time, *my* Space, *my* Becoming, *my* Being, *my* existence serve as experiential contents. We wonder now *how* they are experienced, that is, how they will merge into my experiencing in respect to relations and meanings. The meanings of space concern seizing* (seizability). Although there are relations in the experiencing of *my* Space, we recollect that all experiential relations are Time-bound: before-now-afterward (successive). We do not experience the flux of "pure" Time, but Time "filled" with events and experiences; through them we become aware of our Becoming.** Regardless of their (temporal) successiveness, events have to pass through Space and our experiences roll off in our Space. In Space our experiences receive their meanings due to their "seizability." *My* Time implies relations, *my* Space implies meanings when I experience them as contents. One may dare say that world-Time implies relation and world-Space implies meaning.† There is no danger of one-sidedness, since Time and Space are inseparable, so are *my* Time and *my* Space.‡ There can never occur any experiencing in Space and of Space without Time (and without relations), nor any experiencing in Time and of Time without Space (and without meanings). However, the emphasis seems to change from the temporal to the spatial and vice versa in individual experiencing.*** Psychopathological phenomena show that the factor of Time (and relations) or the factor of Space (and meanings) may come into the foreground or recede into the background of the experiencing of certain patients.

III

Notwithstanding the observations on the present†† I always experience (in my) Now-Here. When I move away from my present

* See p. 549 text and fourth footnote.

** Where I am here, I cannot Be there. But I may have Been there, before I Was here, and I may afterward, i.e., after Being here, Be there. This implies the motion that I go forward in Time, I Become. There is no experiencing which would be merely spatial and timeless. Vice versa, I Become from Then via Now to another Then, only since I Was, Am and shall Be in any Space. There is no experiencing which would be merely temporal and spaceless.

† This essay will not go into a discussion of the priority of Time over Space. Milič Čapek has made pertinent remarks in his paper "Relativity and the Status of Space" (Review of Metaphysics, December 1955). Some of his ideas have supported, other have stimulated, several trends in this discussion.

‡ See p. 548.

*** See pp. 549-550.

†† See pp. 550-551.

"Here," I can do it in every one of the spatial dimensions. I can move from the front to the back, from above to below, from right to left or vice versa.* In whichever spatial direction I choose to move, the direction in Time is always the same: forward. *De facto,* I cannot move from any Here without moving from a Now.** Whatever I "do," I cannot but do it in (my) Time and (my) Space; there are always to be relations due to Time and meanings due to Space. The meaning implicit in Space seems to be specially "verified" in the choice and decision I make in respect to the spatial direction of my (voluntary) movements. The forward of Time does not leave us any choice or decision; we have to go along with it. In some pathological conditions, the "Time-sense" seems to be disturbed once in a while. There are patients who tell us that no Time exists at all, that Time stands still or even moves backward. These patients seem to oppose the flux of Time, they "spatialize" Time, experiencing a variety of changes in the meanings of Space and its contents (melancholic and schizophrenic conditions). Other patients (compulsives) are preoccupied with their Time, the advance of which toward their deaths keeps them worried no end.†

Like any other aspect of experiencing, Time and relation, Space and meaning can be followed through the sexes and the various ages. In both sexes, the emphasis can change from Time to Space, from relation to meaning.‡ The speed in which the passing of Time is experienced has often been noted. Time seems to pass slowly to the child, faster, though, to the playing than to the bored child. With increasing age Time appears to go by faster and faster when and if, we may observe, relations get multiplied and diversified. In addition to occupation and individual variations, there is the undeniable fact that death comes more and more close.

It is essentially due to the person in situation how far after a normally fast and erratic adolescence he is able in his prime to integrate his experiencing in his Becoming and Being. The importance of such integration is particularly clear in psychopathological failures, for example in the paranoic and compulsive ways of experiencing.

* Six possibilities altogether.

** This is nothing but the old recognition that movements occur in Time and Space, not either only in Time or only in Space.

† See pp. 555, 556, 557, 559.

‡ See p. 553.

IV

Temporal relations and spatial meanings can be considered the basis of all the relations and meanings of human experiencing. There is no relation without a temporal, no meaning without a spatial, implication. From the viewpoint of existence, Becoming is full of relations, Being is full of meanings. This is also true for our relationships to other human beings, for our relationships to our world and for our relationships to ourselves. Relations may have meanings and meanings may have relationships, particularly when they serve as experiential contents. Such relational meanings and meaningful relations may appear to be most conspicuous in individuals in the experiencing of personal interrelationships, but they occur also in the experiencing of relations to things, to interests, to activities, to plans, to ideas and ideals. There are instructive examples in pathological ways of experiencing. One thinks again of the paranoic and the anancastic ways of experiencing.*

The paranoiac is thought of here as a person in situation whose way of experiencing is essentially oriented toward relations. It is assumed that in paranoic experiencing, relations and Time are somewhat determining factors. The relations which have definite meanings for the paranoiac refer generally to people, mostly to hostile, or at least unfriendly, people. The world of the paranoiac is a human world (*Menschenwelt*) in which the hostilities come from human sources. The paranoiac Becomes in Time, but his experiences are by no means "space-less"; his adversaries live in Space and their machinations hit him in Space. The paranoiac does not presume that his persecutions come from a world of things (*Sachwelt*). If he refers them to apparatus and if he builds apparatus for his protection he presumes that the offending machines are operated by his enemies and that the protecting gadgets aim at them.

Quite different the anancastic. He is experiencing in a world of things (*Sachwelt*); he does not refer the cause of his suffering to people. His world of things extends in Space. His enemies are dirt, chaos, death. The anancastic can, of course, not live and experience "timelessly," although he may desire to do so. Occasion-

*There is no interest in this context in clinical groups or entities, but only in the ways of experiencing. If the words, paranoic and anancastic (compulsive), are used, they are used for the sake of brevity.

ally he may deal with Time as though it were a thing among other space-bound things. This phenomenon can be observed among scientists, philosophers and artists. The ruminative, endless repetition, the inability to get away from a thought or an action (or omission), the "sticking to the material," the rigid perfectionism are obvious in the exasperating endlessness of numerous publications. In the literary field, Marcel Proust is an example; he wrote and wrote and wrote on end and with an extremely detailed circumstantiality. Rather early he retired from the human world to the world of things within his four walls, making a thing out of Time and treating it accordingly. Like many anancastics, he appeared to be caught in Space. There are reports concerning the lack of order and cleanliness in Proust's living quarters.*

Certain anancastics seem to get "stuck on the spot," while paranoiacs keep moving on the forward course. The paranoiac recollects his past and anticipates his future, if in a somewhat distorted manner. Terrorized by dirt, chaos and death, the anancastic seems to barricade himself in his Now-Here.

No paranoiac can experience without Space, and no anancastic can experience without Time. The paranoiac finds and fights his enemies in Space** though he does not seem to temporalize Space in a manner corresponding to the anancastic's attempt at spatializing Time.

In healthy people, factors of Time and of Space seem to tend toward some equilibrium; they are experientially integrated. The lack of such integration is evident in the paranoiac and in the anancastic. Both have a tendency toward perseveration which one may think of as an attempt at compensating for the lack of temporal-spatial integration. Perhaps perseveration is a sort of bridge between these two very different ways of experiencing. Perhaps this very "bridge" makes it possible for them to occur in the same individual, successively, and, if infrequently, simultaneously.

V

This attempt to disentangle the intertwinings in and between the "couples," Time-Space, Becoming-Being, Relation-Meaning, is one of many interpretations. One cannot experience, or deal with the

* It is hardly necessary to say that Proust and his work cannot be fully understood from his anancastic way of experiencing, which seems to have dominated the second (productive!) half of his life.

** See p. 555.

experiencing of others, without interpretation.* Whatever we seize through our senses from reality, we may immediately "subject" to some interpretation. From whichever source my experiential contents are coming to me, *I* accept them, *I* deal with them, *I* get impressions which *I* relate to other experiences, and which *I* endow with meaning; *I* either express or do not express them. As a person in situation, I am equipped with assets and liabilities with which I am exposed to the influences of my environment (world); my experiences and interpretations bear the imprint of my individuality. There are, of course, many common features between me and other individuals—both on a biological basis, and due to the cultural-social background. The members of the species *homo sapiens* share the ability of experiencing and interpreting, a prerogative, which enables the human individual to face himself and to look at himself, as it were, from the Outside.

In the two first sections of this paper, Inside and Outside were discussed. To turn to them once more, using as paradigms the paranoic and the anancastic ways of experiencing, one conjectures that interiorization refers more to Time, exteriorization more to Space.** It is assumed "that in paranoic experiencing relations and Time are somewhat determining factors." One concludes that, through the experiencing of relations and Time, interiorization prevails in the paranoiac (direction from the Outside to the Inside in the world of man). The paranoiac, indeed, experiences, in a world of man in which his enemies experience, too, and in which he is exposed to their hostilities. He is, however, not hit on his skin, but in his Ego, within which he more and more withdraws; this is pathological interiorization.

The anancastic experiences in his Space-bound world of things. The more he desires to remain clean and to keep everything in order the more insuperable become dirt, chaos, and "behind" them death, which he endows with dirt and chaos. The anancastic is prone to collecting and hoarding a variety of things. Some of these things might be useful, but not for the anancastic as he just "sits" on them. He even "squats" upon Time as though it were a thing among other things.†

* The writer seems to remember that Jaspers once remarked that dealing with the experiences of others was "interpretation of interpretation."

** Cf. p. 550.

† See p. 556.

The paranoiac may be looked at as a caricature of the healthy "Time-person" (*Zeitmensch*). The Time-person progresses in Time and in relations. For him, living and experiencing are motion, promise and fulfillment. His Inside enables him successfully to maneuver the Outside. The anancastic may be viewed as a caricature of the normal "person of things" (*Sachmensch*). For him, living and experiencing represent a duty which is sometimes tolerable, rarely pleasant and mostly not easy to live up to. The "person of things" is exteriorizing, occasionally with heroic effort, into the world of things.

The utter extremes of these "types" never occur in reality, but there are "mixtures" galore.

VI

A variety of authors have in one way or other pointed out the resemblance of certain delusions to religious ideas and the resemblance of paranoic experiencing to religious experiencing in respect to content, formulation and systematization. Kraepelin called paranoia "a kind of falsified *Weltanschauung*." Bumke wrote, "Delusion is a matter of belief not of knowledge." Manfred Bleuler states that "delusional ideas (*Wahnideen*) have their normal analogue not in error, but in belief." He emphasizes that "the difference is not an absolute one." It is always necessary to get a clear insight into, and understanding of, the experiencing person in situation. What in one case is experienced as due to divine providence, may be a delusion in another case. Many experiences which in the past were adjudged as supernatural in the social-cultural group would pass for delusional (paranoic) experiences today. On the other side, there are nowadays many everyday experiences which former social-cultural groups would have deemed due to satanic influences or to insanity.

Paranoic experiencing does not begin suddenly, but is preceded by a condition of uncertainty and doubt in which suspicion may become more and more outspoken. Religious faith is not reached all of a sudden. The searching individual often experiences insecurity and doubt, with painful intensity, in his fight for faith. In both instances, doubt can be conquered as long as the certainty of belief lasts.

It is different with the anancastic. He is unable to overcome his doubt in the religious as in any other area of experiencing. "Self-

defense becomes the very task of his life" (Kraepelin), which he tries to fulfill in a "wide system of superstitious relations, conjurations and symbolic actions" (Kraepelin). Their similarity with the rites and ceremonies of primitive religions is well known; this similarity remains within formal range; here, too, anancastic exteriorization appears to be unmistakable. The belief of the paranoiac and the faith of the devout are interiorized.

The interpretation thus leads to assuming that inner relations exist between paranoic and religious experiencing, while there seem to be only external ones between anancastic and religious experiencing. This assumption appears to fit in with the profane contents of anancastic experiencing—dirt, chaos and a notion of death corresponding to them.

One is tempted to opine that in general the anancastic may be incapable of experiencing the Holy, the *Numinosum*—an experience presumably also strange to the man of things in his world of things. One might conjecture that there is an area of transition between the experiencing of the devout and the experiencing of the paranoiac, within which mystical experiencing might possibly be included.

However, with these remarks the discussion has entered into a region of asking and wondering in which no answer can be expected from the psychiatrist.

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EDITORIAL COMMENT

AMENTIA EX MACHINA

Amentia ex machina! It is no moon strike when a machine fails to function; but it may be heartening for humanity just the same. Few psychiatrists, therefore, will be acutely unhappy over the failure of the New York Hospital-Cornell electronic computor to do as well as a human doctor in diagnosing psychoneuroses.*

Working on the same data as the doctor—questionnaire answers—the computer identified 42 per cent of the psychoneuroses that were listed in the hospital records of 350 patients. The doctor, on preliminary diagnosis, did about twice as well—his score was 81 per cent of the total. The computer seems to have suffered from an episode of amentia ex machina, if amentia can be episodic.

It appears to be one thing to hand Unilunivak or Umptitoodilak a barrelful of astronomical data and get back in two days a result that all the world's astrophysicists couldn't reach by concerted effort in 20 years, and quite another thing to ask it to take a punch-card record of a questionnaire and tell what is the matter with the churned-up psyche of an individual human. In the case of non-psychiatric diagnoses of the same 350 patients, the machine did better; it actually diagnosed 48 per cent of the diseases present correctly, while the competing physician diagnosed only 43.

As a matter of good mental as well as physical health, one does not encourage the practice, but diagnosis by the layman of certain common disorders is not too difficult, and such diagnosis should be no harder for a well-designed machine. In this investigation (using a total of 2,745 questionnaires), a "conventional high-speed electronic data-processing system, programmed to make diagnostic decisions in a manner analogous to that of an unbiased physician," diagnosed 100 per cent of its small sample of five male epileptics correctly; it recognized four of seven female epileptics; it identified 78 per cent of 46 men and 81 per cent of 151 women suffering from obesity; and it detected 72 per cent of 57 men and 77 per cent of 60 women with hemorrhoids. It may not be a snide

*Brodman, Keeve; van Koerkom, Andrianus J.; Erdmann, Albert J., Jr.; and Goldstein, Leo S.: Interpretation of symptoms with a data-processing machine. Arch. Int. Med., 103:5, 776-782, May 1959.

remark that an intelligent high school senior should have done about as well; and the report of the researchers does not dispose of the possibility that these simpler diagnoses contributed heavily to the machine's nonpsychiatric successes. Yet (on the basis of the 350 records that both machine and doctor considered) where would that leave the human diagnostician, who came in, in the score for somatic disorders, 5 percentage points below the machine? Both machine and doctor diagnosed solely from the answers to 195 questions on an examination form known as the Cornell Medical Index-Health Questionnaire (CMI).

Is the machine superior in the instance of somatic disorders because in all cases it must take account of all factors, while the physician may lose track of some of them in the crowd? The score on the psychoneuroses suggests that if this is part of the answer, it is not the whole answer. The machine went to school. It had, for instruction, the records (CMI answers, age, sex and diagnoses), covering an 18-month period, of 5,929 consecutive adult white patients (2,718 men and 3,211 women) admitted to the out-patient departments of the New York Hospital during the 18 months beginning on July 1, 1948. Then it applied its learning (diagnosed the syndromes so determined) to the 2,745 adult, white, out-patient admissions to the hospital during 1956. In their report, Brodman et. al. remark: "It was required of the machine system that it develop empirically its own diagnostic criteria. No a priori information, based on the experience and knowledge of the medical profession, was made available to it. Instead, the machine system was instructed how to determine diagnostic syndromes, from each patient's sex, age and medical complaints, correlated with hospital diagnoses. These were the only data of which the system had knowledge. Beyond set programs, the machine was given no human assistance in its development and use of the syndromes. . . . the system identified syndromes of complaints on the CMI characteristic of the diseases studied here. The syndromes 'discovered' independently by the machine proved to be in all important aspects those already known to the medical profession." The syndromes or diseases studied in the 1956 investigation were the 60 most commonly found among the men and the 60 most common among the women of the 1948-1949 sample used for the machine's instruction.

The machine, however, does not seem to have distinguished itself by identifying the psychoneuroses, even though "discovering," recognizable psychoneurotic syndromes in its nearly 6,000-patient instruction sample of 1948-1949 patients. Yet psychoneurosis was by far the largest single diagnosis in both men and women in the 1956 study. There were 449 cases in the hospital records among the 2,745 patients of the 1956 study; the machine diagnosed 46 per cent of the men and 31 per cent of the women correctly. In this comparison with the hospital records, the machine did not do too well, considering that it must have had nearly 1,000 psychoneurotic cases (if the proportion held) from which to learn a pattern in its 1948-1949 instruction sample.

For comparison with the doctor, both machine and doctor had 350 CMI records (1956), picked at random; and of the results, the report remarks conservatively, "The superiority of the physician in diagnosing psychoneurosis appears to be a consequence of his having knowledge of a large number of cases of this protean disorder, both from his own experience and from the reports of others. The machine did not have the benefit of this knowledge."

The principal author of the machine-diagnosed report is a psychiatrist; and one takes issue with him respectfully and with diffidence. But is he not making allowances for the machine on the strength of the generally-known difficulty and complexity of psychiatric diagnosis? Was not the machine, in diagnosing somatic syndromes, also competing with a doctor who had also seen many cases and read reports of many more? The difference is not clear.

If the machine can add up "questionnaire symptoms" of polydipsia, polyuria, bulimia, pruritis, dermatosis and visual disturbances (these symptoms are purely hypothetical) and come up with a syndrome that physicians recognize as diabetes mellitus, why can it not add up compulsions, conversions, philias and phobias and come up with something recognizable as a psychoneurosis? It seems that it can, sometimes, but only sometimes, recognizing about two out of five psychoneurotics from their questionnaire answers, while the psychiatrist recognized four out of five.

Our scientists specializing in electronics can construct machines which can and do process humanly-supplied data much faster than the human brain can—and without human parapraxes of omission or mistake. But there seem to be some areas in which the more

fallible physiological and psychological processes in the human brain are superior to electronic thinking.

The electronic diagnostician does considerably more than add, subtract, divide and multiply. It collates its information, relates one datum to another, identifies patterns of relationship, and produces conclusions. If it were human, one would call this process logical thinking. One would also consider it a very good grade of logical thinking and a highly superior form of mentation, for—within the limits of its information—the machine makes no errors. It cannot overlook a datum or willfully omit one from its calculations because it doesn't "fit" a pattern. It cannot misunderstand, and its attention cannot wander. It cannot treat data according to likes and dislikes—suppressing, repressing or forgetting. It cannot make errors because of fatigue or emotional pressure. It is not swayed from accurate observation by influences from the conscience or the unconscious, since it has neither conscience, nor, in the human sense, an unconscious—omissions of some utility when strictly logical thinking is to be served!

The electronic thinking machine is, in fact, something like the ideal human mental pattern envisioned by some psychologists some 40 years ago. The psychodynamics of this school interpreted mentation as a simple and direct reaction to direct stimulus. A reaction to a stimulus established a pattern; and succeeding reactions to similar stimuli followed the established pattern and so were conditioned reactions. The process was the same whether the stimulus was sitting on a carpet tack or confronting a problem in chemical engineering. The most efficient person or the most efficient mind was the one which responded the most promptly and appropriately to any given stimulus. Indecision or emotion was a waste of time, and the goal was to eliminate them; unhesitating, instantaneous reaction was the objective in human thought process. The electronic thinker does precisely that; and the "primitive Pavlovian" school would have approved of it highly.

This is the point at which it seems appropriate to observe that others than the primitive Pavlovians do not regard these characteristics as entirely desirable. Speed, logic and accuracy are not the only desiderata in human thought. Not only existing machines, but those projected for the foreseeable future, lack certain useful human capacities. Even those invented by the more scientific of the science fiction writers do not approximate human mentality.

The better science fiction—the sort which finds readers among scientists from medical residents to astrophysicists—depends upon extrapolation, which Webster defines as a process of projecting into an unexplored field observations made in a field that has already been explored. To lead to plausible fiction, the extrapolations must be based on known scientific data and developed by logical reasoning. They must be based on a formula which presumes that, given this or that not impossible if not foreseeable development, such-and-such a scientific and technological setting will characterize the world of the future. For example, Edwin Balmer and Philip Wylie, a quarter of a century ago, anticipated the modern developments of the feedback principle, and improved upon them to the extent of visualizing machines which, when bearings burned out, stopped and repaired themselves.*

Balmer's and Wylie's machines did not think. But the machine that does think is very much part of the picture of other good writers' views of the world of the future. And except for Arthur C. Clarke, scientist and recognized authority on problems of space exploration, whose creation of "Vanamonde," a disembodied intelligence, is across the border of an extrapolated world in a never-never land of fantasy,** the science fiction writers of high repute have generally projected their thinking machines within limits suggested by presently functioning models.

Colonial Survey† is a tale by Murray Leinster (otherwise chemist and professional writer, Will F. Jenkins), who has a considerable reputation as a student of actual scientific developments. The "colonies" of his survey are planets scattered over the galaxy; and, on one, infested by so many inimical carnivores that a strictly human colony is impractical, there is an attempt to colonize with a few men and many electronically-controlled robots. The attempt fails when the animals overwhelm an electrified fence and destroy the men who direct the robots. As Senior Colonial Survey Officer Bordman is compelled to concede, the robots are helpless by themselves: "... you can't make a hunting robot. A machine can discriminate, but it can't decide. ... They [robots] can't decide to do something for which they have no instructions." And Bordman re-

*Balmer, Edwin, and Wylie, Philip: After Worlds Collide. Lippincott. Philadelphia. 1934.

** Clarke, Arthur C.: Against the Fall of Night. Gnome. New York. 1953.
——: The City and the Stars. Harcourt, Brace. New York. 1956.

† Leinster, Murray: Colnial Survey. Gnome. New York. 1957.

marks, "That's why there's no danger of a robot revolt." Sophistication has arrived since the days when Karel Čapek's robot did stage a revolt in *R.U.R.* A robot with the capacity to rebel may not be inconceivable, but it no longer seems reasonable extrapolation. (For the benefit of the inquisitive, what Leinster's colonizing men and robots could not do was accomplished by men and domesticated Kodiak bears, the bears having the ability, which robots lacked, to make decisions.)

So it is with the robots of Robert A. Heinlein,* an engineer whose people and situations are most persuasive. In the near-future of 1970, electronic tubes supply the brain for "Flexible Frank," "a docile moron, capable of largely repetitive household jobs." Heinlein extrapolates a bit to produce a remarkable "memory tube": "... you can hook a Thorsen tube into a control circuit, direct the machine through an operation by manual control, and the tube will 'remember' what was done and can direct the operation *without* a human supervisor a second time, or any number of times. For an automated machine tool this is enough; for guided missiles and for *Flexible Frank* you add side circuits that give the machine 'judgment.' Actually it isn't judgment (in my opinion a machine can never have judgment); the side circuit is a hunting circuit, the programming of which says 'look for so-and-so within such-and-such limits; when you find it, carry out your basic instruction.'"** Flexible Frank could, thus wash the dishes or change the baby; and 30 years later, "Eager Beaver" and Frank's other great-grandchildren could do practically all the housework, tend gardens, or serve as hospital orderlies. (All without using "judgment.")

Perhaps the ultimate in "high-grade" science fiction robotics is presented in Jack Williamson's *The Humanoids,* which is presum-

* Heinlein himself gives the scientific background of some of the robot-creators in a recently published symposium on science fiction writing (The Science Fiction Novel, Imagination and Social Criticism. Advent. 1959.): "There are close relationships between scientists and science fiction writers—indeed some of them are both." Heinlein notes of some discussed here that Arthur C. Clarke is "a distinguished science fiction writer and scientist," that Philip Wylie has a degree in physics, that "Murray Leinster" is a chemist, and that "Dr. Isaac Asimov teaches at the medical school of Boston University, does research in cancer, writes college textbooks on biochemistry..." He notes that he himself is "a mechnical engineer who once specialized in mechanical linkages and... worked in industrial engineering," and that his wife is a "microchemist and microsurgeon"—all matters that have been determinants of mechanical and other constructs in Heinlein stories.

** Heinlein, Robert A.: The Door into Summer. Doubleday. New York. 1957.

ably a satire and which pictures hundreds of thousands of worlds in the whole galaxy under the control of robots who obey a "prime directive" to "Guard Man from Harm," a project which, being machines, not men, they carry out with such efficiency and lack of discrimination as to destroy all human initiative.* This QUARTERLY commented on the tale at the time; it seemed to have certain political, psychological and social implications.**

Unquestionably, the most interesting to the psychiatrist of the electronic minds of the future, are those contrived by Isaac Asimov. Mr. Heinlein is an engineer; and his robots operate with electronic tubes. Mr. Asimov is a biochemist who is on the faculty of the Boston University School of Medicine; and his robots have electronic thought processes on the model of the human brain. "All that had been done in the mid-twentieth century on "calculating machines" had been upset by Robertson and his positronic brainpaths. The miles of relays and photocells had given way to the spongy globe of platinumiridium about the size of a human brain."† Mr. Asimov records the story of robotic development, as told to a writer by Susan Calvin, Ph.D. (1982-2064), the world's first "robopsychologist." The Asimov robots' sensory perceptions make brainpaths in the platinumiridium sponge; the result is something analogous to the presumed human mental system. An Asimov robot, unlike a Heinlein or a Leinster robot, can work "his precise mechanical mind over the highest functions of the robot world—the solutions of problems in judgment and ethics." The Asimov robots, dedicated to the first law of robotics, "A robot may not injure a human being, or through inaction, allow a human being to come to harm," finally assume "the absolute control of our economy." It was the first "World Co-ordinator," himself presumably a robot, who remarked of this, "'How horrible!'" and Dr. Calvin who amended it to "Perhaps how wonderful! Think, that for all time, all conflicts are finally evitable. Only the Machines, from now on, are inevitable.'

"And the fire behind the quartz [in the electronically-controlled fireplace] went out and only a curl of smoke was left to indicate its place."

* Williamson, Jack: The Humanoids. Simon and Schuster. New York. 1949.

** Editorial: Statism—infantilism of society. PSYCHIAT. QUART., 23:4, October 1949.

† Asimov, Isaac: I, Robot. Gnome. New York. 1956.

After this bit of symbolism—which the author does not seem to be too happy about—Dr. Calvin concludes the story of the robots, "*'I saw it from the beginning, when the poor robots couldn't speak, to the end, when they stand between mankind and destruction.'*"

Toward what end do these informed speculations lead the electronic diagnosing computer of 1959? Today's electronic diagnostician lacks many human abilities. So do the suppositious electronic minds of the science-fiction future. Most of them lack the ability to form judgments. Those who can form judgments can form them only within a strictly limited framework. All are strictly governed by rigid human directives, which must be obeyed with the utmost literalness. Williamson's humanoids are able to pass for human beings; so are Asimov's robots. But the humanoid channels of thoughts are regulated for all humanoids, everywhere in the universe, by a single master grid, devised by wholly human intelligence. One of Asimov's robots poses as a man and acts as a detective in a mystery story of the far future. But the robotics expert says of him:* "... the essence of the robot mind lies in a completely literal interpretation of the universe. It recognizes no spirit in the First Law [that a robot cannot harm a human being], only the letter." And, "A human understanding of abstractions cannot be built into a positronic brain in the present state of our knowledge." There are obvious limits to what Asimov considers allowable extrapolation; to stretch them even as far as he has, he has been obliged to go from biochemistry to the invention of something approaching biometallurgy. Yet in the light of Remington Rand's "deposited memory cores"—"thin [.1 microns] film memory cores produced through vacuum deposition of molten metal"—sponge platinumiridium "positronic brains" may seem almost conservative concepts, particularly when one notes that today's actually existing "deposited memory cores" represent an "important step toward micro-miniaturization of computer components."**

The superiority of the robot—anybody's robot—over today's computer is primarily in the ability of the machine of the future to gather and process its own data, using electronic eyes and ears instead of punch cards. To this data-collecting ability, must be added infinite improvements in the directions of feedback, of motility, of communication, and of variety of possible reactions

*Asimov, Isaac: Caves of Steel. Doubleday. New York. 1954.

**Current national advertising by Remington Rand Univac.

to the conditioning stimuli. The future robot's "thinking ability" is vastly in advance of that of the computer; but the gap, it now appears, may be narrower than is commonly supposed. Construction of a machine that can (and will) reproduce itself by gathering its own raw materials has already been studied. In a current unsigned review of the subject, the "medical newsmagazine" *MD* remarks: "A self-reproducing, thinking machine, capable of adapting itself to its environment may be nearer than anyone thinks."*

A machine can compute and classify, and can learn and recognize combinations, infinitely faster and more accurately than can the human mind. But it can act, nevertheless, only by human directive and only according to humanly-supplied rules and instructions. When one is designed to reproduce itself, it will still do so according to humanly-contrived instructions, built into the original model and copied faithfully in each succeeding "generation." The machine has no conscience and no discretion. Pending the invention of the "positronic brain," it has no judgment. It has a memory bank, more accurate and more readily drawn upon than that of the human mind—for strictly limited data. But it has nothing resembling the human unconscious; it has no capacity for sympathy, identification, hate, love, or even empathy. It has no emotion and no capacity for emotion. And—above all where diagnosis is concerned—the machine has no intuition, no "clinical hunch," not even a "mechanical hunch."

What makes a good diagnostician has always been a subject of discussion. To take sharp issue with the New York Hospital-Cornell experimenters, the ability to diagnose certainly requires more than minute and accurate observation and the recognition of syndromes thereby. This, the machine can already do—given that the minute and accurate observation is of holes in a card. But diagnosis, and, in particular, psychiatric diagnosis, it may be contended, involves an element of unconscious or intuitive perception and interpretation. The psychiatrist, however he himself may describe the process, may be said to see a personality picture, not a collection of data he can classify into syndromes. If the psychiatrist could see such pictures, and beat the New York Hospital-Cornell computer two-to-one on the basis of questionnaire data, it would be most interesting to see how much better he could do if

*Feature story: Mechanical man. MD. 3:9, 178 183, 1959.

he could observe the patient, taking advantage of all sorts of nonverbal material that could not be given to the machine.

There is no intent here to belittle the New York Hospital-Cornell machine, or any machine. Machines are playing an increasingly important role in surgery: the "artificial kidney," for one; the machine recently used to keep the blood circulating during cardiac surgery, for another. Physiotherapy is largely machine therapy; and electric shock is a psychiatric treatment administered by machine. The electrocardiograph and the electro-encephalograph are indispensable diagnostic machines. The x-ray is a machine process; centrifuges, microtomes, autotechnicons, spectrophotometers, and other machines are widely used in laboratory procedures; in fact, laboratory work itself resembles a machine operation in its carefully channeled, impersonal handling of biological material. The better the laboratory, the more machine-like, parts of it are.

The model of a good psychological test is also like the model of a machine. Most of the intelligence tests could be scored readily by machine; and it seems likely that a machine could be instructed to process such things as Rorschach data adequately; it would be interesting, in fact, to compare what a good psychologist and a well-instructed machine would do with blind analyses of the same Rorschach scores (no machine yet devised could be expected to use the judgment required for the actual scoring).

The machine, today's machine not that of the future, is useful wherever physical data are to be processed. It could, for instance, handle laboratory data very nicely. In a recent, informal discussion, somebody remarked that a central establishment for machine processing of laboratory data might be very useful. The reasoning is that, in today's world there is much traveling and much shifting of population, with the result that both specialist and general practitioner confront medical conditions with which they may not be familiar. A machine in a central office—say, in Boston—could store information from specialists familiar with conditions in all parts of the world. It could learn the patterns of such disorders as have distinctive patterns that are shown by standard laboratory procedures. A physician from any part of the country could send or telephone his laboratory findings to the central office; a punch card would be prepared; and, if a recognizable distinctive pattern existed, the machine would identify it—in a fraction of a second. This is only a logical, minor development, at least qualita-

tively, from the diagnostic functioning of the present New York Hospital-Cornell computer, differing only in that the proposed computer's data would be more reliable and its education more extensive. It would use for computations only strictly objective and factual laboratory material; and it would have, stored in its memory, not data patterns that it itself had identified, but patterns that laboratory experts from all over the world had found to be diagnostic of specific diseases.

A service such as this might not be economically feasible or professionally acceptable; the question is not of material concern here, since few psychiatric conditions are diagnosed by laboratory work-up, and the service would be of use principally to identify purely somatic disorders. It is merely an illustration of one thing, not now done, that the present-day machine can conceivably do now for medicine.

This whole discussion, in fact, might well have started from what machines can do here and now, instead of from what the experts at extrapolation dream up for the machines of the future. Extensive use is already being made of machines in the field of psychiatry. In a large psychiatric hospital or department, a machine is as likely as not to file patients' and personnel records or make up the payroll. The central office of the New York State Department of Mental Hygiene has a system of which its statisticians are very proud. Patients' records are cut on machine punch cards. If one wants a list of all male patients over 30, admitted for the second time to New York state hospitals since VJ Day with the diagnosis of manic-depressive psychosis, depressed, the machine can supply it—with names, addresses and some details of hospitalization.

In army or navy, or in giant corporations, or in scientific work generally, machines are doing the kind of thing just illustrated. Machines have been doing jobs like calculating ballistic tables for some years now. UNIVAC was making up and typing out General Electric payrolls, including typing the checks, as much as five years ago; ENIAC has been solving complex scientific and engineering mathematical problems for about 15 years.*

George Gamow gives a sensational illustration of the uses of machine calculation in science. Seven or eight years ago, the cos-

*Lessing, Lawrence P.: The automatic office. In: Automatic Control. Edited by the editors of Scientific American. Simon and Schuster. New York. 1955.

mologists were much exercised over an astronomical-explosion sequence. It starts with comparatively mild, periodic stellar explosions (the type star is U-Geminorum, which huffs or puffs a little—though more than enough if it were our sun, to wipe out our planetary system—every 97 days), through the violently exploding novae, which may or may not burst out periodically every 10,000 years, to the supernovae, which may blow up in fireworks that outshine the entire galaxy and which can probably only perform the feat once. A number of astronomers developed the theory that the explosion sequence represents the successive outbursts of a single star, which begins by mild huffing and puffing and finishes with what Gamow calls the "fantastic blow-up" of a supernova. They also had a tentative explanation, and they believed they had the data to prove or disprove a theory which they considered was, after all, "based largely on intuition and guesswork." But Gamow estimated that processing the data would take 100 human computers 100 years. So the astronomers were waiting in the hope of using a new species of electronic computer, one of which was under construction at Princeton and another at Los Alamos. Gamow estimated that the problem could probably be solved in about a week by this new type of electric brain, which he noted, was facetiously called MANIAC,* a title the psychiatrist should cordially applaud.

The capacities of the *idiot savant* are much like those of MANIAC. Mathematical computations from logarithmic tables to the equations of general relativity have often been done in the past with the aid of human mathematical freaks, people with the ability to produce the cube root of 13 in a second or two, or the tenth power of 63 in a couple of minutes. MANIAC's ability to do 10,000 years of computing (100 x 100 years) in a week is of the same sort, if incredibly faster; and MANIAC shares another characteristic with the human lightning calculators. Many of these people played important parts in the development of both practical mathematics and theory; Einstein, for instance, was notoriously poor at arithmetic; and he relied on a man with freakish calculating abilities for the ciphering part of his work—today, instead, he might be using an electronic machine. But neither the machine nor the human lightning calculator has, of necessity, any ability beyond lightning calculation. One or two of the human lightning calcula-

*Gamow, George: The Creation of the Universe. Viking. New York. 1952.

tors have been men of real genius,* but many have been true *idiots savants*, aments possessing a single ability in a mentality otherwise of imbecile or even idiot level.

Most of the accomplishments of today's machines are of the *idiot savant* variety, though, as in the instance of the New York Hospital-Cornell calculator, some can be taught to detect specific groupings of data and to report when they encounter them again. Limited numbers of specific conditioned reactions are built in, and the machine operates by repeating processes it has learned by rote, simulating the reasoning of its builders and teachers. An introductory note—over the initials of the *Archives'* chief editor, Paul S. Rhoads, M.D.—to Brodman and his associates' article on machine diagnosis** remarks: "The machine described here merely correlates symptoms set down by the patient and draws conclusions on the basis of what it has 'learned' from physicians. Hence it makes the same errors as the human brain which 'taught' it plus others that are inherent in its inability to initiate the thinking process." The note adds that a reviewer of the paper raised the question of the type of machine errors, remarking, " 'If a patient with flat feet is simply not so diagnosed, this is one type of error, but if the machine reads, "respiratory tuberculosis inactive," it's another.' " One may assume, from what information is supplied as to the nature of the machine, that the error here is of the former type and that the lung and foot conditions would have to be coincidental in large numbers of patients for the machine to mistake one for the other.

As "P.S.R." sums up the machine advantages,† the computer "does eliminate the factors of emotional bias and fatigue, which may confuse the issue when a physician tries to analyze the complex of subjective complaints which the patient serves up to him." No one will dispute that this is an advantage, particularly in the diagnosing of physical conditions; but the machine also eliminates

*A young mathematical wizard of the genius variety (IQ 186) is currently in the news. The Associated Press reports that 12-year Butch (real name withheld) has been solving problems in calculus since he was seven. California State Polytechnic College and a missile-parts firm, Leach Corporation of Los Angeles, are reported to be setting up a private electronics laboratory for him, supplying meters, tubes, spaghetti and the like and arranging to supervise his training. The report does not say whether he will have an electronic computer; but it seems probable that he could struggle along without one.

**P.S.R.: Introductory note. Arch. Int. Med., 103:5, 776, May 1959.

†Ibid.

the factors of emotional understanding, empathy, identification and insight.* The machine lacks imagination (in the literal sense of the word); it cannot form images of things not present, consider, weigh and accept or reject them as they fit the circumstances presented in the form of data. It has no capacity whatever for abstraction. And it has no intuition.

The assumption seems proper that Brodman and his associates can educate their machine to recognize the psychoneuroses oftener and with greater certainty than in the test they reported. The machine is capable of learning and recognizing combinations of complaints; in the test, it identified its own combinations from "sex, age, and medical complaints [as elicited on the CMI questionnaire], correlated with hospital diagnoses." Or, "From the CMIs of the 1948-1949 sample [5,929 patients], the machine system determined the frequency with which patients having a given disease made each complaint and compared to it the frequency with which all patients in the sample made the same complaint. From these comparisons the machine derived the probable association between a specific complaint and a given disease." (It has already been noted that the syndromes the machine identified as characteristic of specific diseases were "in all important aspects" those already known to physicians.) There seems to be no reason why combinations that the machine failed to recognize from the CMI cannot be taught to it by its schoolteacher physician.

Brodman and his co-authors say of their investigation:

"The claim is frequently advanced that the process of drawing correct diagnostic inferences from a patient's symptoms is in large part indefinable and intuitive. It is the purpose of this communication to show that the making of correct diagnostic interpretations of symptoms can be a process in all aspects logical and so completely defined that it can be carried out by a machine."

As to the questionnaire-diagnosis of some somatic disorders, the investigators may well rest their case as supported by the evidence; the machine can do it. It would be interesting, nevertheless, if the machine were to be educated by direct, expert instructions as well as experience and then pitted against the most

*Of the science-fiction prognosticators discussed here, only Asimov has imagined a machine with any emotional capacity whatever—and this, the childish emotionality of the *idiot savant*: the result, a practical joke on an extragalactic scale. (Op. cit., I, Robot.)

experienced diagnostician the authors could persuade to co-operate.

As for the psychoneuroses, the authors appear to have disproved their case. If they want to re-try it, the suggestion seems in order that the psychiatrist who defeated the machine endeavor to add to its education first. A contest between a machine with "post-graduate" psychiatric training and a psychiatrist with similar training should be worth reporting; and this journal, for one, would like to see a report on it.

Pending such an investigation, it may be submitted that the process of psychiatric diagnosis involves the use of imagination (in the literal sense), abstraction, empathy, emotional understanding, identification, insight and intuition. For the purposes of diagnosis, intuition may be considered a process of seeing and weighing the all but imperceptible evidence behind the evidence. If these qualities are actually involved, one may still expect confidently the man to outdo the machine. No machine at present known or projected can receive nonverbal communications of the kind involved here. And the very best robots (Asimov's) of the science-fiction prophets of our perhaps apocalyptic future lack most or all of the essential qualities. None can do abstract thinking; that is, they all are completely literal-minded; none have emotion or understanding of emotion; none have intuition.

Mechanization and automation have done a lot of folks out of jobs, from ditch-diggers to statisticians. The psychiatrist's job should be safe enough—until somebody builds a machine with capacity for "clinical (or mechanical) hunches."

BOOK REVIEWS

American Handbook of Psychiatry. Two volumes. SILVANO ARIETI, M.D., editor; 111 contributors. x and 2098 pages, with indices, notes and illustrations. Cloth, 7¼"x10½". Basic Books. New York. 1959. Price $25.00 (Special price to December 31, 1959, $19.95).

The two encyclopedia-sized volumes of this modestly-titled "handbook" cover psychiatry in the United States with considerable detail and considerable authority, from Benjamin Rush to chlorpromazine. They form a practical text, could be employed for collateral reading, are more than adequate for ready reference, and contain much material of direct worth in clinical practice, besides presenting adequate summaries of the principal current theories.

Arieti's editorial board was made up of Kenneth E. Appel, Daniel Blain, Norman Cameron, Kurt Goldstein and Lawrence C. Kolb; and they assembled a roster of 111 contributors whose names read like a "Who's Who" in American psychiatry in general, in the New York State Department of Mental Hygiene in particular, and—if the reference is permissible—like a "Who's Who" of contributors to this QUARTERLY. Scientific collaborations also make strange bedfellows; if those gathered here are all contented, they are all philosophers as well as medical scientists. The diversity, of course, has the great advantage of presenting all shades of opinion and practice from their upholders' points of view. For example, Walter Freeman writes on psychosurgery, Lothar B. Kalinowsky on convulsive shock therapy, Benjamin Malzberg on statistics, and J. L. Moreno on psychodrama. Nolan D. C. Lewis introduces the work with a short history of American psychiatry. Abram Kardiner writes on the traumatic neuroses of war. The "functional" psychoses are discussed by the editor himself, and by Norman Cameron, Newton Bigelow and Johannes M. Meth. Paul H. Hoch contributes the paper on the new drugs and drug therapies in general; William A. Horwitz covers insulin shock therapy. The discussion of forensic psychiatry is by Winfred Overholser; in material from fields related to psychiatry, Gardner Murphy writes on social psychology; Anatol Rapport takes up mathematics and cybernetics; and religion is discussed by representatives of the Protestant, Catholic and Jewish faiths, with additional comment on the Oriental religions.

Four articles deal with the relations of neuroanatomy, neurophysiology, neurology and neuropathology to psychiatry—under the authorships of James Papez, R. W. Gerard, Stanley Cobb and Leon Roizin. Jules H. Masserman takes up the biodynamic approaches to psychiatric problems, and Paul H. Hoch writes on pharmacologically-induced psychoses. Under

the general heading of management and care, Virginia Bellsmith contributes a chapter on social work, and Hester B. Crutcher one on family care.

The handbook contains strong sections on the psychoneuroses, psychosomatic medicine and organic conditions. Since the editor's selective hand is much in evidence, there will be considerable criticism of some decisions: the devotion of 19 pages to classic Freudian psychoanalysis, for instance, and twice as much space to the divergent schools. It is fair here to observe that the classic psychoanalytic point of view is presented directly elsewhere in the handbook in connections other than that of psychotherapy; and the indirect influence of Freudian theory is, of course, obvious in numerous contributions. The editor's preface notes that a guiding principle in selection of articles "was that of presenting a check and balance between different approaches whenever it was feasible. ... Chapter 28, by Cleckley, which discusses psychopathic states, is predominantly nosologic; counterbalancing this is Johnson's Chapter 42 on juvenile delinquency, which is psychodynamically oriented." The reviewer thinks the general balance achieved is, on the whole, admirable.

The 15 sections of the handbook concern themselves with general considerations, the psychoneuroses, the "functional" psychoses, psychopathic conditions, psychosomatic medicine, diseases of childhood and adolescence, language and communications, organic conditions, the psychotherapies, the psychoanalytic therapies, the physical therapies, relations with basic sciences and experimental psychiatry, contributions from allied fields, management and care, and finally, legal, administrative, didactic and preventive psychiatry.

The *American Handbook of Psychiatry* is a beautifully printed and bound book, well selected and well edited, and the reviewer thinks that its publisher, editors and contributors are to be congratulated on an important and greatly needed contribution to psychiatric education, theory and practice.

Body and Mind in Western Thought. By JOAN WYNN REEVES. 403 pages including index. Paper. Penguin. Baltimore. 1958. Price 95 cents.

Dr. Reeves' book is a valuable introduction to the history of psychology, and a collection of well-selected readings. It contains a very readable and reasonably objective review of psychological theory from the days of ancient Greece to our own. This is both comprehensive and useful. The readings are well chosen but there is an unfortunate omission of Freud, although his position is covered, if briefly, in the historical survey. This book should be useful for teaching, for collateral reading, or for general orientation.

Principles of Self-Damage. By EDMUND BERGLER, M.D. 469 pages including index. Cloth. Philosophical Library. New York. 1959. Price $6.00.

Principles of Self-Damage should be of primary interest to the practising psychoanalyst. It compresses into less that 500 pages material from what the author estimates to have been 70,000 analytic appointments over a period of 30 years, not to mention (the author doesn't) an almost unbelievable amount of reading and studying. The book develops Bergler's thesis that psychic masochism is the primary neurotic defense against super-ego tyranny, and presents the application of the theory in psychoanalytic practice and in the incidental interpretation of life situations in general, and of situations in literature. Drawing on his vast material, some of which has previously been presented in numerous books and articles, the author gives example after example of the protean forms this defense takes.

Principles of Self-Damage starts with a discussion of the genesis of psychic masochism, outlines the theory, presenting supporting clinical evidence, takes up questions of typology, relates the problem to intuition, and closes with a 44-page discussion of "Typical Technical Errors in Clinical Analysis in Our Transitional Period." The field of this text is very broad. Bergler illustrates his thesis from the analyses of numerous patients, from self-analysis, from an analytic criticism of some of the published works of Theodor Reik and from reviewers' misapprehensions about Bergler's own books. The present reviewer thinks that the book should be of great use to those among the author's colleagues who can approach it without too much resistance, and of considerable use in the orientation of non-psychoanalytic practitioners. It is deceptively easy to read; comprehension is something else.

The Psychology of Interpersonal Relations. By FRITZ HEIDER. 322 pages. Cloth. Wiley. New York. 1958. Price $6.25.

Heider's underlying assumption is that "scientific psychology has a good deal to learn from common-sense psychology" and his purpose is to sketch, albeit tentatively and incompletely, a conceptual scheme that will utilize and clarify common-sense notions about interpersonal relations. Because he is interested in systematizing, the book, although studded with illustrations of everyday behavior, is not easy reading. His analyses of such concepts as desire, pleasure, envy, retribution, likes and dislikes, norms and values are detailed, thoughtful and perceptive. Heider does not present a well-worked-out theory, but as he points out, the book is a set of notes toward such a theory. It is, however, an important first step and should receive serious consideration.

On the Mysterious Leap From the Mind to the Body. FELIX DEUTSCH, M.D., editor. 265 and IX pages, with bibliography and index. Cloth. International Universities Press. New York. 1959. Price $5.00.

This monograph originated from a workshop on psychosomatic problems. "The mysterious leap from the mind to the body" is a phrase in which Freud referred to the riddle of the conversion process.

In the discussions, it is emphasized that "investigations of this problem are based on the formula: projection-loss-symbolization-retrojections and re-embodiment. The concept of conversions as a continually active process in the organism plays a part in any normal and neurotic condition, since the psychic life expires without the embodiment of the symbols which can be called the 'soul of the organism.'"

Dr. Deutsch is of the opinion that in the future this postulate may replace the concept of "psychogenesis" and might even substitute for the term "psychosomatic." These contributions are interesting in showing how psychosomatic and psychoanalytic research can be related to each other by focusing on such an all-inclusive concept as conversion.

Psychoanalysis and the Social Sciences. Volume V. WARNER MUENSTERBERGER, Ph.D. and SIDNEY AXELRAD, D.S.Sc., editors. 289 pages with index. Cloth. International Universities Press. New York. 1958. Price $6.00.

This fifth volume of *Psychoanalysis and the Social Sciences* contains articles covering a wide range of topics: anthropology and religion; psychological mechanisms underlying the effectiveness of pictorial advertising; and social values and the ego ideal. There are other attempts to describe normal adaptive functioning and mechanisms, and to distinguish them from neurotic defenses, written by experts in their fields who have made this volume an indispensable source of information for psychiatrists, as well as others interested in social science.

Neurotic Distortion of the Creative Process. By LAWRENCE S. KUBIE, M.D. 149 and V pages, with index. Cloth. University of Kansas Press. Lawrence, Kas. 1958. Price $3.00.

This book presents an interpretation of the relationship between the neurotic and the creative processes that is significant for the development of creativity in art, literature and science, and an interpretation that is also a challenge to some educational assumptions that psychological illness is necessary for creativity. The reviewer thinks the author has succeeded in his aim to present a study that will be understandable, not only to the technician, but also to the thoughtful reader who is not trained professionally in the psychoanalytic field.

Aggression. By JOHN PAUL SCOTT. IX and 149 pages with indices. Cloth. University of Chicago Press. 1958. Price $3.75.

This book represents the conclusions of nine years of study of the problems of aggression, covering fighting in the animal kingdom and relating or contrasting it with human behavior. It was assumed that aggression could be studied more clearly and objectively in other species rather than man, since understanding the causes of fighting is a very complex and difficult study in mankind.

In this project aggression was examined from psychological, physiological, hereditary, social and ecological bases. Discussion of its causes, control, consequences and possible solutions is based on the conclusion that all stimulation for aggression comes from the external environment and tends to be social in nature, and that there is no evidence of a physiological spontaneous, driving force for fighting. In the light of this conclusion, the author contends that aggression can be controlled by scientific creation of environments which do not stimulate aggression between individuals and small groups. Assuming that this is a long and difficult task, the reviewer could not find suggestions for accomplishing it indicated clearly anywhere in the book.

Mystery on the Mountain. The Drama of the Sinai Revelation. By THEODOR REIK. xiii and 210 pages with index and notes. Cloth. Harper. New York. 1959. Price $3.75.

Dr. Reik takes issue on Freudian grounds with Freud's own well-known interpretation of Moses and the story of Sinai. Freud's suggestion that Moses was an Egyptian of noble birth, who carried the outlawed monotheistic tradition of Ikhnaton to the oppressed Jews, has met criticism on historic grounds, and much condemnation in Jewish religious circles. Reik disputes Freud on archeological and psychoanalytic grounds, and in the light of much knowledge not available when Freud wrote. His interpretation will meet, however, with no more enthusiasm from the orthodox and the chauvinistic. That interpretation is that the form of the Sinai story, as we have it in the Bible, is a survival of primitive initiation or puberty rites. Whether this is the framework for a revelation and a theophany, is a question that the author appears willing to leave to the theologians; but he draws on a vast amount of Biblical, anthropological and archeological material to present a convincing argument that the events of Sinai at least fall into the form of a mystery drama. That this is an important book and one which should be of great interest to the student of religion and of the human mind alike, seems evident enough to call for no special emphasis.

Individual Psychology. By A. ADLER. 352 pages including index. Paper. Littlefield, Adams. Paterson, N. J. 1959. Price $1.75.

The Nature of Mathematics. By MAX BLACK. 219 pages including bibliography and index. Paper. Littlefield, Adams. Paterson, N. J. 1959. Price $1.50.

Scientific Thought. By C. D. BROAD. 555 pages including index. Paper. Littlefield, Adams. Paterson, N. J. 1959. Price $1.95.

The Logical Syntax of Language. By R. CARNAP. 352 pages including bibliography and index. Paper. Littlefield, Adams. Paterson, N. J. 1959. Price $1.95.

The Growth of the Mind. By K. KOFFKA. 427 pages including notes and index. Paper. Littlefield, Adams. Paterson, N. J. 1959. Price $1.95.

Crime and Custom in Savage Society. By B. MALINOWSKI. 132 pages including index. Paper. Littlefield, Adams. Paterson, N. J. 1959. Price $1.50.

Bentham's Theory of Fictions. By C. K. OGDEN. 161 pages including appendices and index. Paper. Littlefield, Adams. Paterson, N. J. 1959. Price $1.75.

Judgment and Reasoning in the Child. By J. PIAGET. 260 pages including index. Paper. Littlefield, Adams. Paterson, N. J. 1959. Price $1.50.

The eight volumes reviewed here are among the first publications of a new paperback library, The International Library of Psychology, Philosophy and Scientific Method, which is reissuing standard work of more or less interest to psychiatry.

Adler's *Individual Psychology* is his famous book which outlines his theory and practice of psychotherapy. Whatever position one takes toward Adler and the psychoanalytic movement from which he seceded, it is seldom questioned that he was a great clinician with many important insights. His principal work belongs in any psychiatric library.

Black's *The Nature of Mathematics* is a standard work covering the main schools of mathematical philosophy. The reasoning is important for general science and has its applications in psychiatry.

Broad's work on scientific thought covers the major aspects of the important twentieth century views of the universe. Broad takes up concepts of space, kinematics, the first theory of relativity, the general theory of relativity, the theory of sensa, date and duration, space-time, and other important subjects. Any scientist should find this book useful for information or reference.

The Logical Syntax of Language is a highly technical work, dealing with symbolic languages and the theory of language. The author says: "The book itself makes an attempt to provide, in the form of an exact

syntactical method, the necessary tools for working out the problems of the logic of science."

Koffka's *The Growth of the Mind* is a useful text covering the principal facts of intellectual and sensory development. Its basis is the Gestalt theory and it does not stress emotion or dynamics. Students of psychology will find it useful.

Malinowski deals with the primitive thinking which, it is often assumed, lies back of our own ways of mentation and our own civilized institutions. In the book reviewed here, he demolishes the often-encountered theory that savage man lives in a straightjacket of compulsions and taboos. He finds, on the contrary, that his Trobriand Islanders react to their personal and social obligations much as more civilized men do, bearing in mind, of course, differences in theory and in the application of sanctions.

Ogden presents Jeremy Bentham as a precursor of today's students of semantics. Bentham went from the study of law and the perception of legal fictions to the perception that language in general is full of fictions. In language, we treat an idea or a function as if it were a thing; Bentham points out that this is the employment of a fiction. His ideas are thus of great importance to the scientist and to the psychiatrist in particular, whose study frequently involves the private fictions of mental disorder as well as the public fictions of language in general.

Piaget's work was first published in English some 30 years ago. It is a standard work in the very limited area of child psychology to which it applies. Both psychiatrist and psychologist should find it of value.

The reviewer thinks the reprinting of the works reviewed here is important both to general and mental science. The format is convenient; the printing is generally good and the prices are better than reasonable. The publishers deserve congratulations and good wishes.

Long-Term Illness. MICHAEL G. WOHL, M.D., editor. XIX and 748 pages. Cloth. Saunders. Philadelphia. 1959. Price $17.00.

The subtitle of this book is "Management of the Chronically Ill Patient," and it is management that is stressed. The 79 contributing authorities deal with everything nonpsychiatric from headache to multiple sclerosis. The emotional factors involved in long-term illness are consistently recognized as a basic problem in the disease.

This book should be of great value to many physicians as a source of quick reference. The basic facts concerning etiology, etc. are here, but in abbreviated form. The result is a group of articles where the suggestions for medical management are not buried under detail.

This book can also be recommended without reservation as a reference for school of nursing libraries. The material presented is in easily comprehensible form, and methods of nursing care are suggested in many articles.

Introduction to Cultural Anthropology. By MISCHA TITIEV. 464 pages including index. Cloth. Holt. New York. 1959. Price $6.00.

This is an introductory volume, intended as a college textbook, and for general reading by persons unacquainted with anthropology. It opens with a brief survey of evolution and physical anthropology, proceeding to a study of the "biological foundations of culture" and then illustrating, by anthropological material from all over the world, various forms of cultural and social achievement. Aside from its value to any student who can continue to make use of anthropological insights, there is much material here of value for the teaching of tolerance and of mental hygiene generally. There is an interesting, if brief, discussion of mental disorder from the anthropological frame of reference, in which it may be seen as the result of a conflict between biological and social forces. Even if not used directly for teaching, this volume should be of use in the medical school or school of nursing library.

Existentialism and Education. By GEORGE F. KNELLER. 170 pages, with index. Cloth. Philosophical Library. New York. 1958. Price $3.75.

Kneller attempts in this book to apply the principles of existentialist philosophy to the reform of our present educational system. The crux of his thesis is that the center of man's existence is the individual himself rather than the group; and he urges restoration, in the schools, of emphasis on thinking for one's self—as contrasted with pressure to implant predigested and approved ideas on large masses of students. Kneller's approach is logical and thoughtful, and he quotes prodigiously from Sarte, Kierkegard, Heidegger, Jaspers and others. But he never actually offers any practical solutions for the educational dilemma that he premises. Inherently, he can't; for adapting the Existentialists' viewpoint and feelings (although denying he is an Existentialist), he must, as they do, also deny universals and absolutes. There are moments of truth in this essay, a stark portrayal of the basic educational problem, and a shining faith in man's individuality and creativity. However, it is in terms of solutions and practicality that this book is felt to fall short.

Introduction to Symbolic Logic and Its Applications. By RUDOLF CARNAP. 241 pages. Paper. Dover. New York. 1958. Price $1.85.

Carnap's approach to symbolic logic is better adapted to the beginning student than are most. There is, of course, no more a royal road to understanding here than in other mathematical disciplines. The person who will take the time and exercise the patience, however, to follow this text will find decidely worthwhile contributions to his knowledge of reasoning. The subject, of course, is becoming of more and more interest to the worker in the psychological and social sciences.

Screening Procedures for Experimental Cancer Chemotherapy. C. CHESTER STOCT, consulting editor. 562 pages. Paper. New York Academy of Sciences. New York. 1958. Price $5.00.

This monograph is the report of a conference on the methods used in screening possible chemotherapeutic agents against cancer. Included are the effects noted in microbiological studies, tissue cultures, ascites tumors, lymphomas, hormone responsive tumors, transplantable human tumors, special systems, and other considerations in experimental chemotherapy, including chance observations.

There are three qualities which make this monograph very interesting. One is the criticism of the methods used. The second is the results obtained. The third is that all the methods used are found in the one volume.

The serious investigator will find much room for thought here; the average physician will realize the vast amount of research in the cancer field. The beginner in research may find direction indicators. This monograph comprises pages 409-970 of the *Annals of the New York Academy of Science*, Vol. 76, Article 3, and the *Annals* deserve considerable favorable comment on the high standard of this publication.

Behavior and Evolution. ANNE ROE and GEORGE GAYLORD, editors. 557 pages with index. Cloth. Yale University Press. New Haven. 1958. Price $10.00.

This is a highly anticipated, monumental volume comprised of about 25 essays of contributors from both the American Psychological Association and the Society for the Study of Evolution, and is the culmination of several of these societies' interdisciplinary committee meetings. It is a masterfully planned, and thoroughly organized series of articles, which attempts to synthesize the basic facts and principles of behavior and of evolution, as indicated by the title. Each article is scholarly, and most lean upon overwhelmingly long reference lists (a notable exception being Julian S. Huxley's "Musings upon Cultural Process and Evolution").

The unifying theme threading its way throughout the complex and diverse material is that behavior is an outcome of the historical process of evolution and is subject to the general principles of biological evolution to no less a degree than morphology or physiology. If one feels a slight let-down on closing the pages of this book, or a feeling that publication has been premature, the criticism is of the current stages of psychology and biology, rather than of the book itself, which is remarkable in its inclusiveness, and in accurate reflection of theories and facts by qualified biologists and psychologists.

"Behavior" itself is left undefined and unclassified. The hope is expressed that "known neurological parameters are more than adequate to

account for any conceivable complication of behavior merely by architectural modification of finite numbers of neurons." What has actually been accomplished here is a promise of fruitful co-operation of the biological and psychological disciplines, and a bird's-eye view of the current status of both, pointing to future avenues of profitable, substantial and desirable synthesis.

The authors included here are George Gaylord Simpson, Edwin H. Colbert, Alfred Sherwood Romer, Frank Beach, Ernest Caspari, R. W. Sperry, Karl Pribram, Theodore H. Bullock, Henry W. Nissen, Marsten Bates, C. R. Carpenter, R. A. Hinde, N. Tinbergen, Harry Harlow, W. R. Thompson, Alfred E. Emerson, Ernest Mayr, Herman T. Spieth, Colin S. Pittendrigh, S. L. Washburn, Virginia Avis, J. S. Huxley, Lawrence V. Freedman, Anne Roe, and Margaret Mead. The book includes many helpful illustrative figures.

Don't Worry About Your Heart. By EDWARD WEISS. 203 pages. Cloth. Random House. New York. 1959. Price $3.95.

A highly popularized discussion of various aspects of heart disease is written by a prominent psychosomaticist. As usual in such cases, too many concessions are made, with the aim to reassure. The masochistic elements are not worked out.

Psychopharmacologia. Vol. 1, No. 1. E. ROTHLIN and A. WIKLER, managing editors. 89 pages. Paper. Springer-Verlag. Berlin. 1959. Price $2.40.

Psychopharmacologia, a new review in the field of psychopharmacology, has brought out its first issue under the sponsorship of an international editorial board, with E. Rothlin of Basel and A. Wikler of Lexington, Kentucky, joint managing editors. American members of the editorial board include H. Waelsch of the New York State Psychiatric Institute; and Americans on the advisory board include H. C. B. Denber of Manhattan (N.Y.) State Hospital and Nathan S. Kline of Rockland (N.Y.) State Hospital.

The first issue is made up of six articles in English and one in French. Contributors are from the United States, England, France and Denmark. The journal is published in Germany by Springer-Verlag. It measures about nine by six inches; the articles in the first issue cover 78 pages, and in the opinion of the reviewer it is overpriced. It is intended to be brought out at irregular intervals. An issue will appear whenever, and as soon as, suitable material is available; and the total subscription price for a year is expected to be about $19.00. The contents of the second issue, already announced, include seven articles in English, one in French, and one in German by J. Delay.

The contents of the first issue are: "Behavioral Pharmacology," by M. Sidman; "Relationships of Psychotomimetic to Anti-Serotonin Potencies of Congeners of Lysergic Acid Diethylamide (LSD-25), by H. Isbell, E. J. Miner and C. R. Logan; "Comparison of the Reactions Induced by Psilocybin and LSD-25 in Man" by H. Isbell; "The Influence of Side-Effects on the Reporting of Symptoms," by F. J. J. Letemendia and A. D. Harris; "*Étude psychométrique des effects de l'amobarbital (amytal) et de la chlorpromazine sur des sujets normaux*" by J. Delay, P. Pichot, P. Nicolas-Charles and J. Perse; "Effects of Chlorpromazine on Acquisition and Extinction of a Conditioned Response in Mice," by V. H. Denenberg, S. Ross and J. Ellsworth; and "Lithium in Psychiatric Therapy," by M. Schou.

The Elements of Style. By WILLIAM STRUNK, JR. and E. B. WHITE. 71 pages. Paper. Macmillan. New York. 1959. Price $1.00.

The Elements of Style is a little book once circulated extensively among the students of Professor Strunk and others at Cornell. It has been revised here by E. B. White, and a chapter on writing has been added. Most teachers and professional writers of English will agree on the general principles condensed here. The condensation itself is an extraordinary achievement; and any writer, including any professional writer, can profit by a little study of this book. The writer of technical and scientific articles can learn from it quite as much as the writer on more general subjects.

Myasthenia Gravis. By KERMIT E. OSSERMAN. IX and 286 pages. Cloth. Grune & Stratton. New York. 1958. Price $10.00.

The need for a comprehensive and up-to-date book on myasthenia gravis has long been obvious. Osserman's book fills this need in a concise manner and is intelligently and practically organized. It includes a good chapter on the pathology of different organs in the disease and a straightforward account of the abnormal physiological background, insofar as we understand this. The chapter on specific drug treatment is built up on this background.

Because of the pleomorphic nature of the disease and the "spontaneous" variation in patients with it, one of the most thorny aspects of myasthenia gravis has always been differential diagnosis, and one is gratified to find a chapter entirely devoted to this subject. Although the more common confusions are discussed, this chapter does not touch upon the problem of so-called equivalents. Neither does it go into the difficult problems which the psychiatrist sometimes encounters in attempting to separate the various factors which can be seen in patients with myasthenia gravis who are also psychoneurotic and, perhaps, alcoholic. Such patients, it is true, are not seen very often and it would be too much to expect all nuances of the

disorder to be considered in detail, but it must be borne in mind that even patients who have been demonstrated in teaching clinics as true myasthenia gravis and who have been on prostigmine for years sometimes end up in psychiatric institutions where, not being known to have had the disorder, they go along for years without specific medication and without evident mishap. According to Osserman, somewhat better than 10 per cent of patients develop, and remain in, remission and it is certainly necessary to re-examine cases frequently in order to avoid indefinite consideration of such cases as ongoing.

The Golden Age of Quackery. By STEWART H. HOLBROOK. 302 pages including index. Cloth. Macmillan. New York. 1959. Price $4.95.

The Golden Age of Quackery is a lively and well-written history of the great patent medicine era. It will certainly arouse in some readers nostalgia for the days of youth when Castoria and Peruna advertisements punctuated the rural landscape. The account ranges from "Extract of Sarsaparilla," "Swamp Root," and "Doan's Pills," to "Lydia Pinkham's Vegetable Compound" and "Dr. Wilson's Restorative." Besides the view the book gives of nineteenth century America and Americans, there are many fascinating anecdotes. There is, for instance, the occasion on which Asa T. Soule failed with a bribe of a $100,000 endowment to get the University of Rochester re-christened "Hop Bitters University," after his patent medicine.

This is an easy-reading, popular work. The reviewer thinks, however, that almost any physician will enjoy it and be enlightened by it, and that its indirect revelations of popular psychology should interest the psychiatrist and psychologist.

Sigmund Freud's Mission. An Analysis of His Personality and Influence. By ERICH FROMM. 120 pages. Cloth. Harper. New York. 1959. Price $3.00.

In this little book, Fromm attempts an analysis of Freud's personality. He deals with his attitudes toward his parents, toward men and women, toward love and authority. Most of Fromm's materials are drawn from Jones' biography so that the reader will find little that is new about the events of Freud's life. Fromm's interpretation, however, differs markedly from Jones'; and in some ways, the book may be considered a lengthy critique of Jones' picture of Freud.

A personality appraisal of a great thinker is most valuable if the analyst can show how his subject's characteristics helped mold his thought. By this test, Fromm's book is only partially successful. He is persuasive when he suggests that some of Freud's views on sex are rationalizations of Freud's "inhibited sexuality." But when Fromm asserts that Freud's views on the primal horde, the Oedipus complex and Moses are linked

to his hostility to his father, he is far from convincing—not because the notion is unsound (clearly it is not) but because the evidence of Freud's hostility to his father is remarkably thin.

If the book is not one of Fromm's better works, it is, nevertheless, one that all serious students of Freud will want to read.

Handbook on Standard Nomenclature of Diseases and Operations. By EDWARD T. THOMPSON, M.D., and ADALINE C. HAYDEN, C.R.L. Prepared for American Medical Association. 71 pages. Paper. Blakiston Divison, McGraw-Hill. New York. 1959. Price $1.50.

This pocket-size (4⅜"x6⅜") booklet is a book about a book. It is a description and explanation of, and a guide to the use of, the 1952 edition of the *Standard Nomenclature,* and it is intended for "physicians, interns, residents, and medical students." Some of the material covered can be found in, or inferred from, the *Nomenclature* itself; but some very useful matter is not noted specifically and cannot be inferred. For example, the *Handbook* lists more than 120 unacceptable diagnostic terms (about three pages of them), and 22 pages of unacceptable eponyms often used in diagnosis, with the official terminology given for the latter. The unacceptable terms include such things as "war neurosis," "cerebral accident" and "neurasthenia." Among the unacceptable eponyms listed are: Pick's disease, Alzheimer's disease, Bell's mania, DaCosta's syndrome, Froehlich's syndrome, Huntington's chorea, Sydenham's chorea, Korsakoff's psychosis, and Sachs-Tay disease. Areas of disagreement are covered here, and it is a relief to note that "Hutchinson's teeth" is still an acceptable description.

The *Handbook* contains much other useful material, such as notes on distinctions which should be observed between pathological findings and the disease entities to which they correspond, notes on the proper use of syndromes, and notes on recording diagnoses of suspected diseases. Any user of the *Nomenclature* is likely to find that the *Handbook* facilitates its use; and new users in particular may find it essential. This reviewer hopes that some way will be found to include the *Handbook* material in the next (fifth) edition of the *Nomenclature* itself, which is scheduled for 1961.

A Manual on Terminology and Classification in Mental Retardation. Monograph Supplement to American Journal of Mental Deficiency. Prepared by RICK HEBER. 111 pages. Paper. The American Association on Mental Deficiency. Willimantic, Conn. 1959. Price $2.00.

This manual follows in general the major ideologic divisions of the *Standard Nomenclature of Diseases and Operations.* There are some instances in which, it is explained in the introduction, it was felt that "changes were dictated by advances in knowledge..." The hope is ex-

pressed that the inconsistencies resulting will be eliminated when the *Standard Nomenclature* is next revised.

The present monograph is in the format of the *American Journal of Mental Deficiency* to which it is a supplement. Under "Medical Classification" the manual gives an outline of the classification, covers the category definitions, gives the code equivalents for the *Standard Nomenclature* classification and lists categories with International Statistical Classification and *Standard Nomenclature* equivalents. A section on behavioral classification follows.

Statistical reporting is discussed and illustrated, and there is a comprehensive glossary of terms frequently used in mental retardation. An appendix gives proposed reporting forms for institutions for the mentally retarded. This monograph, of course, will be of primary use in the institutions and clinics dealing with mental deficiency; but it should also be of wide use to other institutions and to psychiatrists in private practice who may have occasion to examine or treat mental defectives and who need an approved guide for reporting or keeping records of their cases.

Best Cartoons of the Year 1959. LAWRENCE LARIAR, editor. Unpaged. Cloth. Crown. New York. 1959. Price $2.95.

Best Cartoons From Abroad 1959. LAWRENCE LARIAR and BEN ROTH, editors. Unpaged. Cloth. Crown. New York. 1959. Price $2.95.

These annual publications are, as usual, ideal presents for reasonably sophisticated folk. Lariar and Roth have an uncanny faculty for the selection of the sardonic.

This year's American selections run the gamut from the Beat Generation to the electronic thinker. There is the usual selection of misogyny and other psychopathology. One of the best examples concerns a psychiatrist investigating hallucinations, and there is a priceless sketch of a space traveler who has just met an extraterrestrial succubus.

The 1959 cartoons from abroad are an unusually good selection, with a fine variety of irrationalities and screwball fantasies. In particular, there are a couple involving voyeurism, one with a keyhole at an art exhibition and one with a pair of binoculars and a statue. Notable also, is a modernized knight in armor who could only be French and whose equipment comes close to the limit of social acceptability.

Both of these volumes are well-balanced and beautifully-reproduced selections.

Straight to the Heart. By GEORGE LAWTON. 338 pages. Cloth. International Universities Press. New York. 1956. Price $5.00.

A psychologist, operated on because of aortic stenosis, reports the experience optimistically. The book is of value to instill courage, and diminish terror connected with heart-surgery.

Pictorial History of Philosophy. By DAGOBERT D. RUNES. x and 406 pages with index and nearly 1,000 illustrations. Cloth, 8½"x11¼". Philosophical Library. New York. 1959. Price $15.00.

This handsome volume is a picture-book of philosophy and related subjects, rather than a history. The work is strongly imprinted with the personality of its author; and, like his *Treasury of Philosophy*, it includes many characters who have small claim to the name of philosopher. It is, however, illustrative of much of the world's philosophical, theological, psychological, political, and scientific development from the beginnings of history to the present. If such illustrations as a portrait of Oliver Cromwell and a sketch of the medieval massacre of the Jews of England (apparently misdated) do not contribute significantly to one's knowledge of philosophy, they do illustrate significant and dramatic events of changing times. Unavoidable minor inaccuracies of fact and unavoidable distortions through condensation will be detected by the informed reader but do not materially affect the general worth of the book.

Personal bias, of course, does affect the value of the book materially; and an outstanding instance of it is apparent in Runes' treatment of Freud, Adler and Jung. He devotes six lines to misunderstanding Freud, seven times that space to a favorable biography of Adler, and nine times Freud's space to a discussion of Jung!

The work is divided into sections which it seems fair to suppose represent the author's personal classification system; it opens with Judaism (from Moses to Martin Buber) instead of with Greek thought, and takes up India and China before reaching Greece. The other divisions are partly chronological, partly cultural: the beginnings of Christianity, the dark era of knowledge, the world of Islam, classics of France, Russia's great century, and so on. The book closes with America's "coming of age," and the final illustration is a mushrooming cloud, inscribed $E=mc^2$. In spite of its drawbacks, *Pictorial History of Philosophy* would make an impressive gift book, although it is not designed for professional reading or for formal educational purposes. It could be used cautiously for very general reference and would be suitable for the living room table, or for the waiting room table of a doctor whose patients included the sufficiently sophisticated. It provides striking background panoramas of many areas of human thought.

Pornography and the Law. The Psychology of Erotic Realism and Pornography. By EBERHARD and PHYLLIS KRONHAUSEN. 371 pages with bibliography and index. Paper. Ballantine. New York. 1959 Price 75 cents.

The authors of this study both hold doctorate degrees in marriage and family life education from Columbia; both are practising psychologists and psychoanalytic psychotherapists; both studied with Theodor Reik,

who contributes an introduction to the present book. *Pornography and the Law* is a paper-bound original which seems to be addressed both to the general public and to workers in the psychological and social sciences. Some of the discussion and some of the conclusions are far too technical for the ordinary reader.

The Kronhausens first discuss the distinction which the law and the public endeavor to make between permissible and prohibited, or acceptable and obscene, books. Erotic realism, which is a part of a picture or reflection of human life as it is, falls, they hold, in the acceptable category; obscenity, or hard core pornography, which is fantasy intended solely to stimulate sexual feelings, does not.

The authors, however, are social reformers. They feel that such erotic realism as appears in Mark Twain's *1601,* in Frank Harris' *My Life and Loves,* in Casanova's memoirs, and in the least expurgated transcription of Samuel Pepys' diaries should be in the acceptable category, in which they are not—to say nothing of such disputed works as Lawrence's *Lady Chatterly's Lover and* Wilson's *Memoirs of Hecate County.* Furthermore, they think the reading of "erotic realism" should be encouraged in the interests of sex education—which is something to be pondered by psychiatrists who consider Casanova's and Harris' sex athletics to have been abnormal. And they doubt whether "hard core pornography," of which they quote very graphic and only slightly Bowdlerized examples, does anybody any harm, or whether any kind of reading, in fact, can do anybody any harm. This is something to be pondered by those who think that Kinsey's dry and sober report of his biased statistics has been creating "statistical" male homosexuals, or by those who recall Radclyffe Hall's beautifully-written and widely-circulated novel of a generation ago, *The Well of Loneliness,* which was credited by some psychiatrists at the time with creating Lesbians who believed hopelessly that they were "born that way."

The Kronhausens argue impressively and cite good supporting authority. The reviewer does not think they prove their case, but he does think that their thesis should be very seriously considered by psychiatrist, psychologist and social scientist in general. Unfortunately, many scientists will fail to appreciate that a serious scientific argument is being presented in a format in which—because of the inclusion of many vivid examples—the book itself will be purchased by many readers as pornography, though this is obviously not the authors' purpose.

What Psychology Says About Religion. By Wayne E. Oates. 128 pages. Paper. Association Press. New York. 1958. Price 50 cents.

This book would be better if re-titled "What Psychologists Say About Religion." It is as objective a review, as could be expected from a pro-

fessor of psychology and religion, of the views of psychologists and psychiatrists whose influence is important in present-day thinking. Some of the interpretations are certainly subject to well-founded adverse criticism; but the work as a whole should be very useful indeed to anybody in the fields where psychology and religion or psychiatry and religion meet.

Subverse. By MARYA MANNES. 144 pages. Cloth. Braziller. New York. 1959. Price $3.95.

Marya Mannes' book is a small volume of light satirical verse—some of it not so light. It is illustrated with considerable sardonic fervor by Robert Osborn; and both verse and illustrations are worth some attention. The professional reader will be interested in "A Matter of Health," a bitter denunciation of the medical-care policies of the American Medical Association. In another satirical verse (this one political, the lady is no Leftist but is emphatically not a conservative) she manages to turn a comma into profanity, a literary achievement this reviewer has never encountered before.

Other matters worth at least mention are Osborn's illustration of "Dichotomy"—which should fascinate any psychoanalyst. Miss Mannes' range runs from the atom bomb and racial prejudice to the stupidity of current fashions. Miss Mannes depicts man as short-sighted and self-defeating, but she shrugs it off. The psychiatrist, who must also shrug it off, should like this book.

Prison Exposures. By ROBERT NEESE. 135 pages. Cloth. Chilton. Philadelphia. 1959. Price $4.95.

This unusual book is a collection of photographs made by a convict within an Iowa prison. The photographs are excellent and the accompanying brief text is illuminating. There is a short foreword, reprinted by permission from a speech by Erle Stanley Gardner, who says, "It is high time we abandoned the prisons of today and the prison theories of today and started looking at the tomorrows in prison." Mr. Neese's book has no stated purpose except that of showing the public how our prisons work and who are the convicts who live in them, and why. It is, however, an encouraging report in that it shows steady and increasing accomplishment through the training and self-education of prison inmates. Without a formally-labeled rehabilitation program, a good many of Neese's fellow-prisoners seem to be on the way toward rehabilitation if they get a little help after release. Among other points implicit in the book is that many of the convicts in this particular prison are in need of psychiatric treatment and psychiatric efforts toward rehabilitation. There is no psychiatric program there.

How to Get Better Schools. By DAVID B. DREIMAN. XVIII and 267 pages. Cloth. Harper. New York. 1956. Price $3.50.

The author stresses the need for community action in obtaining better schools. Many different facets of our educational system are discussed and the role of citizen's groups brought in. When it comes to methods, those proposed are neither new nor startling. They are simply those used for years by any successful political leader.

Parapsychology. By J. B. RHINE and J. G. PRATT. V and 220 pages. Cloth. Thomas. Springfield. 1957. Price $4.75.

The experiments in ESP conducted at Duke University by Dr. Rhine and his associates are very well known, if the subject of much debate. This book is announced as a "survey of the field, the methods and the results of ESP and PK research." This statement is true, but this reviewer would change the stress, as by far the most important section is that on methods. The reviewer gets the impression, perhaps without justification, that a major purpose of this book is to get other research groups to do ESP studies.

The Betrayed. By MICHAEL HORBACH. 240 pages. Cloth. Coward McCann. New York. 1958. Price $3.75.

A belated war-book, written by a German, describes thoughts and actions of members of a decimated platoon in the last days in East Germany before the Russians occupied it. The author neatly divides his characters into fanatics and doubters. One cannot escape the impression that he beautifies his doubters. His title and narrative go to prove that those who felt "betrayed" felt so only because the victory Hitler promised did not materialize. Otherwise, one gathers they would have been willing to accept all the murders of the rotten Hitler regime.

What is Life? By RENÉ BIOT. 96 pages. Cloth. Hawthorn. New York. 1959. Price $2.95.

What Is Life? is a translation from the French of a monograph by a Lyons physician who was formerly associated with Alexis Carrel. It is Volume 32 of *The Twentieth Century Encyclopedia of Catholicism*. It states the religious doctrine of body and soul very clearly, illustrates the application of this tenet to the practice of medicine, and takes up such practical considerations as the Roman Catholic attitudes toward euthanasia and the rhythm method of birth control. The volume is short, and the presentation is clear. It should not only be of use to Catholic psychiatrists but should be informative to all others who want to understand the basic principles governing the thinking of Catholic colleagues in general medical and psychiatric practice.

Language and Psychology. By SAMUEL REISS. 299 pages. Cloth. Philosophical Library. New York. 1959. Price $3.75.

The thesis of Samuel Reiss' book is the application of the bowwow school of philology to modern languages. He holds that contemporary words have unconscious sound-connections with their meanings. The author is well aware of the etymology of the words he discusses; but he applies, nevertheless, a theory which is more often advanced for the suppositious origin of prehuman speech. The reviewer thinks this book is likely to mislead the uninformed and is unlikely to appeal widely either to philologists or psychologists; the psychology, despite its description by the author as unconscious, is on a superficial level.

The *New* Golden Bough. THEODOR H. GASTER, editor. 738 pages including index. Cloth. Criterion. New York. 1959. Price $8.50.

Generally speaking, few scholars have much use for abridgments, especially of classics. Sir James George Frazer's *The Golden Bough* is not only a classic, but it stands in relationship to the later literature in its field almost as Freud's work stands in psychoanalysis, or the Bible in Judeo-Christian religion. Yet Frazer himself abridged it from 12 volumes, in 1922, more that 30 years after its original publication. And his abridgment has gone through numerous editions.

The New *Golden Bough* is a new abridgment, made in the light of more than 35 years of scientific advance since Frazer's own effort, and 18 years after the author's death. It is not only an abridgment but a critical commentary.

Theodor H. Gaster is a distinguished authority himself on religion and folklore, particularly that of the Near East. (He is the author of an excellent translation of the Dead Sea scriptures.) He has made a new selection from Frazer's complete work on the subject—12 volumes of *The Golden Bough* and a supplementary volume—in the light of modern study in the field. Gaster observes in his editor's foreword: "Indeed, what Freud did for the individual, Frazer did for civilization as a whole. For as Freud deepened man's insight into the behavior of individuals by uncovering the ruder world of the subconscious, from which so much of it springs, so Frazer enlarged man's understanding of the behavior of societies by laying bare the primitive concepts and modes of thought which underlie and inform so many of their institutions and which persist, as a subliminal element of their culture, in their traditional folk customs."

Gaster's informative and useful commentary follows the eight parts of the book in the form of "Additional Notes." Notes by Frazer himself which were not included in his own abridgment are also given. As Frazer's own work has become indispensable for the study of culture, Gaster's work should become indispensable for the study of Frazer.

Groucho and Me. By GROUCHO MARX. 344 pages. Cloth. Bernard Geis Associates. Distributed by Random House. New York. 1959. Price $3.95.

Groucho and Me is described on the dust cover as the "Autobiography of Groucho Marx," which it is—more or less. That is, it starts around the turn of the century in the upper east side of New York and winds up in 1959 in Hollywood on the television stage of *You Bet Your Life*. In between is a priceless collection of Americana, connected at least tangentially to the career of Groucho—who scorns ghost writers, declares frankly that he is not writing "a factual, honest and truthful autobiography," which, "to play it safe . . . would have to be published posthumously," but delivers himself of much that is of historical, social and psychological value about vaudeville in its prime, show business and the American scene in general, and finally of TV, criticism of which, he thinks, should be tempered with mercy.

Groucho Marx is a showman. He is also an enormously well-read, thoughtful person with a gift for genuine satire, as well as for ad-libbing flippant, unmalicious, and ironic repartee. The success this latter ability has earned for him needs no emphasis; the grief it has occasionally caused him is memorialized in a short chapter entitled "Foot in Mouth Disease." There are also sardonic discussions of drinking and prohibition, sporting houses and streetwalking, sex and love, among many other things, that almost anybody should find enlightening. It is a pity that Groucho's reflections on love—though they would not evoke 100 per cent psychiatric approval—cannot be widely distributed as a corrective for the ideas so assiduously promulgated in radio and television soap opera romance. And Groucho writes as well as he talks—which is praise enough for anybody.

Counterfeit-Sex. By EDMUND BERGLER, M.D. 380 pages including index. Cloth. Grune & Stratton. New York. 1958. Price $6.50.

Bergler's *Counterfeit-Sex* is an enlarged second edition of *Neurotic Counterfeit-Sex*, first published eight years ago. The enlargement is largely in the addition of clinical material in the discussion of male homosexuality; and there is some revision of the discussion of frigidity, in the light of volume two of the Kinsey studies concerning female sexuality. Bergler's preface to his second edition notes that homosexuality "has become increasingly prominent" because of the use of Kinsey's "erroneous" statistics by homosexuals to recruit "borderline" cases. These, Bergler sees as "statistically-induced" homosexuals. This is a well-compiled, well-reasoned, and useful volume. Its theory is based, of course, on the author's well-known concept of psychic masochism as a defense of paramount importance by the unconscious ego against the super-ego. This work, like its first edition, is to be recommended highly to all professionals concerned with the subject.

Primitive Peoples Today. By EDWARD WEYER, JR. 288 pages including index and 212 illustrations. Cloth. Doubleday. New York. 1959. Price $10.00.

This is a picture-book of anthropology. It is a collection of gorgeous photographic illustrations, many in color, accompanied by brief descriptions of primitive cultures over the length and breadth of the earth. The descriptive notes are simply written but are on a professional level. The result is the sort of book which might have been put together by an anthropologist on a prolonged tour for the National Geographic Society.

The value of a book like this is its presentation of strange peoples and strange customs in a way to make them comprehensible emotionally and intellectually to members of our own sophisticated society. Dr. Weyer presents his condensed information to throw light on the physical anthropology, the racial origins, the religions, the customs followed at birth, adolescence, marriage and death, by a fascinating variety of folk from the Eskimos to the warrior Masai of Africa and the head-shrinking Jivaros of the jungles of South America. The result is a notable contribution to education and understanding. It is also a beautiful piece of bookbinding, illustrating and printing (done in Switzerland)—a remarkable achievement at the price.

The Southern Heritage. By JAMES MCBRIDE DABBS. 273 pages and index. Cloth. Knopf. New York. 1958. Price $4.00.

James McBride Dabbs is a southern writer, a plantation owner, a former university teacher, an elder in the Presbyterian Church in the United States, a lover of the south and a nonbeliever in segregation. Mr. Dabbs traces the history of the south, and/or race relations in the south, and presents the case for ending segregation. His book appears to be an important one for everybody concerned with race problems. This northern reviewer is delighted in addition to see a distinguished southern writer refer, not to the War Between the States but to the Civil War—and to comment without rancor on its outcome.

On Translation. REUBEN A. BROWER, editor. 297 pages including index. Cloth. Harvard University Press. Cambridge. 1959. Price $6.50.

This collection of translators' essays on translating is concerned with literary rather than scientific problems. A good deal of the discussion, however, is just as applicable to scientific work; and the scientific writer who is translated, the translator and the editor of the translation can all profit from the book. Oddly, the article on principles of translation as exemplified by Bible translating can be applied with considerable profit to the scientific field. The essays as a whole could also serve as an excellent collection of illustrative readings on "the meaning of meaning"—or on general semantics.

Education in a Free Society. By Reuben G. Gustavson, Peter Viereck and Paul Woodring. 47 pages. Cloth. University of Pittsburgh Press. 1959. Price $3.00.

This is Volume I of what promises to be an interesting and important series of lectures at the University of Pittsburgh. All three lectures in the present volume touch on problems of considerable concern to psychiatry. Paul Woodring takes up a question that is of concern to everybody perturbed by the problem of how our next generation of scientists is to be educated. Peter Viereck again stresses the theme of nonconformity: "In the long run, human beings refuse to be unfree pushbuttons governed by external material forces, whether economic force or military force." His point of view is most pertinent to the goals of psychiatry, as well as those of education.

The Moral Decision. By Edmond Cahn. 342 pages. Paper. Midland Book. Indiana University Press. Bloomington. 1959. Price $1.75.

The derivation of, and authority for, our standards of morals are matters of concern to all persons interested in the science of man. If scientists cannot derive moral principles from religion, where are they to be found? Professor Cahn believes they can be deduced from a study of the law and that our efforts toward moral progress can be seen in a study of the law. He says, "By merely seeking to ascertain what is righteous we can bring the quality into existence, where it persists until we learn, as we may, to form still more humane decisions."

This is a Midland Book, a paperbound reprint of a publication first brought out by Indiana University Press in 1955. At the present moderate price, this book might well find its way to the shelves of every library of the social and psychological sciences.

Killer's Wedge. By Ed McBain. 181 pages. Cloth. Simon & Schuster. New York. 1959. Price $2.95.

This excellent suspense story concerns a convict's widow who, by means of a loaded .38 and a "bottle of nitroglycerine," holds up a detectives' squad room. A secondary plot is smoothly handled, and the characters, as well as the action, seem plausible.

The End of Violence. By Ben Benson. 220 pages. Cloth. M. S. Mill Co. and William Morrow & Co. New York. 1959. Price $2.95.

Ben Benson writes fine stories of the Massachusetts State Police. One of the best of the fictional detectives, young trooper Ralph Lindsay, stars in two separate cases in this one. Documentation is impressively accurate and all the characters are plausible. Benson's books are among the good things in life that may, one hopes, be looked forward to with regularity.

Kenneth Grahame. A Biography. By PETER GREEN. 350 pages. Cloth. World. Cleveland. 1959. Price $6.00.

In the Holywell Churchyard at Oxford there is an epitaph on a tomb which reads, "To the beautiful memory of Kenneth Grahame, husband of Elspeth and father of Alastair, who passed the River on the 6th of July 1932, leaving childhood and literature through him the more blest for all time."

Peter Green has written an extraordinarily complex biography of the author of *Wind in the Willows*, with interpretive criticism, not only of Grahame's life, but of his changing times. Kenneth Grahame's mother died when he was five; his father, an alcoholic, departed; and he was brought up by his grandmother. A lonely lad, his was a constant search for tranquility. He was liable to persistent fits of depression and pessimism and flights of fancy. He fought a constant battle against the "Olympians," his fictional version of adult influences. He wrote constantly about their unimaginativeness and irritability. He dreamed of attending Oxford, but, because of lack of funds, became a clerk in the Bank of England, eventually becoming its secretary.

A shy retiring man, he married, when he was 40, Elspeth Thomson, brought up in a literary world but with no literary talent of her own. His biographer relates that, through this marriage, he suffered an emotional deprivation; and she, through her unpublished poetry, reflected disappointment of both a sexual and spiritual origin. They had one son, Alastair, born with a cataract in one eye and semi-blindness in the other. He was intensely "nervous" and not particularly intelligent, but his parents endowed him in their imaginations with a high IQ and great popularity, neither of which he possessed. While at Oxford he came to a presumably suicidal end, but with the verdict of accidental death. It was for him that Grahame conceived and wrote *Wind in the Willows*.

The tragedy of Kenneth Grahame is that of a man who could not face his changing times or reality. Yet through his bitterness and non-understanding, he created a world which will entrance adults and children forever.

Nicholas Crabbe. or The One and the Many. By FREDERICK ROLFE. (Baron Corvo) 246 pages. Cloth. New Directions. New York. 1958. Price $4.75.

The dust jacket of this book states "No publisher dared issue it, for its real-life portraits caused threats of libel action soon after its writing around 1905, and it was long thought lost." That two typescripts have recently turned up—now that the disguised characters are no longer alive to file suit—is not, to this reviewer's way of thinking, a matter for rejoicing. The book is one long complaint by a paranoid schizophrenic against

persecutions by his publishers. Added to these woes, are the quarrels and jealousies of a homosexual triangle.

As a patient's own case history, Nicholas Crabbe is of some professional interest.

The Influence of Hormones on Lipid Metabolism in Relation to Arteriosclerosis. By ABRAHAM DRURY and CARLETON R. TREADWELL (co-chairmen) and 35 associates. 267 pages. Paper. New York Academy of Sciences. New York. 1959. Price $4.00.

This monograph forms pages 787-1054 of volume 72 (art. 14) of the *Annals of the New York Academy of Sciences*. By now, everyone knows that cholesterol and dietary fat are important factors in atherosclerosis, but what are the cellular and hormonal factors that regulate lipid metabolism and thus influence lipid deposition in arterial tissue? And the role of the connective tissue ground substance is very poorly understood. The present monograph attempts to come to grips with these questions by a series of papers devoted to (1) metabolism of lipids: biosynthesis, absorption and transport; (2) pituitary and adrenal hormones; (3) gonadal, thyroid and pancreatic hormones; and (4) endocrines and ground substance.

Darwin, Wallace, and the Theory of Natural Selection. By BERT JAMES LOEWENBERG. 97 pages. Cloth. Arlington Books. Cambridge, Mass. 1959. Price $5.00.

This is a delightful book, first issued in a limited edition of less than 400 copies and now presented for general reading as an anniversary memorial of the making public of Darwin's and Wallace's first papers a century ago. Loewenberg's text is a brief account of the circumstances surrounding the joint presentation to the Linnean Society of papers outlining the theory of natural selection. The introduction is followed by the paper presented for Darwin (an excerpt from his later book, *The Origin of Species*) and by Wallace's paper, giving his own reasons for developing the natural selection theory. The volume is beautifully illustrated with reproductions of natural history drawings of a century ago. It is also very nicely designed and printed.

Any scientist should value this memorial of one of the greatest occasions in modern science; and the reviewer thinks it might have a very practical use as well. Loewenberg gives an account of the problem of priority in publication which confronted Darwin when Wallace disclosed that he had arrived independently at Darwin's own conclusions. The behavior of the men most concerned and the resolving of their problem are models of professional etiquette and professional ethics. This small book might very well be used to teach ethics and professional courtesy in any school where scientific training is given.

Shakespeare and His Betters. By R. C. Churchill. 255 pages including index. Cloth. Indiana University Press. Bloomington. 1959. Price $5.00.

Shakespeare and His Betters is a survey of the history and pretensions of those who maintain that Francis Bacon or the Earl of Derby or Queen Elizabeth, or one of a dozen other persons, or one of a dozen groups, wrote the works we now attribute to William Shakespeare. The history is informative for anybody who is interested either in literature or in psychology. It is followed by a thorough criticism in which Mr. Churchill advances enough solid reasons to overwhelm the whole anti-Shakespeare movement. He leaves unanswered several questions of particular import to dynamic psychology, and perhaps they are unanswerable.

What peculiar psychological make-up creates readiness to believe that the greatest literary achievement of our language could only have been attained by an aristocrat? What were the psychodynamics of the originator of the first of the "unorthodox" theories? What leads a person, particularly a lover of literature, to suppose that a person of ordinary antecedents is incapable of greatness? There is a surface psychology of snobbery involved here, besides a general failing to appreciate the realities of Elizabethan life and a general misunderstanding, both of the education and the plays of William Shakespeare. Any lover of a puzzle will enjoy this book, but the psychiatric reader will have to do his own speculating about the dynamics of the pretenders' sponsors.

Mask of Evil. By Charlotte Armstrong. 127 pages. Paper. Fawcett. Greenwich, Conn. 1958. Price 25 cents.

In the present novel the author succeeds once more in giving us a swift-paced, highly suspenseful story. Though perhaps not quite as absorbing as say, *Mischief*, it is nonetheless well worth reading. The author seems well aware of the human capacity for masochism; and the plot of this novel concerns the self-damaging use of guilt. It should be of interest to the psychologist, as well as to the average reader. For whatever reason, the title of this novel was changed for the present paperback reprint. It was originally called—and much more appropriately—*The Albatross*.

What Makes You Tick? Charles D. Rice, editor. 229 pages. Cloth. Harper. New York. 1958. Price $3.95.

This Week is in the habit of presenting to the less intellectual part of its readers "personality quizzes" with score cards. The quizzes are on such a level that the reviewer is surprised to find the editors permitting book publication and a reputable publisher undertaking it. To cite a couple of high points: "How Happy Are You?" "Could You Be A Hero?"

Brown Girl, Brownstones. By PAULE MARSHALL. 310 pages. Cloth. Random House. New York. 1959. Price $3.95.

A sympathetic novel depicts a colored woman from a Barbadian family, living in Brooklyn. Although the author relies too much on the external factors of race difficulties, and cannot (yet) handle the complex psychological problems that are deeply interwoven into externals, the book is readable.

Differential Treatment and Prognosis in Schizophrenia. By ROBERT D. WIRT, Ph.D. and WERNER SIMON, M.D. 198 and XII pages, with index. Cloth. Thomas. Springfield, Ill. 1959. Price $6.50.

The better part of this book is devoted to controlled investigation of chlorpromazine and reserpine. The two drugs are compared with each other in as to effectiveness, and their prognostic values are demonstrated with one-year follow-up examinations. The effects are also compared with other treatments. Chlorpromazine, the authors conclude, is nearly as effective as such other methods of treatment as shock, coma, and psychotherapy. Reserpine, they think, appears no better than simple hospitalization. This volume should be valuable to everybody interested in the field of psychopharmacology.

Assessment of Human Motives. GARDNER LINDZEY, editor. 273 pages. Cloth. Rinehart. New York. 1958. Price $5.00.

This book is the outcome of a conference on the general subject of motivation held at Syracuse University in the spring of 1957. The papers of eight psychologists plus an introductory chapter by the editor have now been put between the covers of a book. Given the subject, which is as broad and vague as it is important, and the original mode of presentation—essentially a series of separate lectures—it is not surprising that the chapters are unconnected and do not add up to a significant whole. The individual papers are generally good and do provide a rich sampling of the field. In addition to papers by Henry Murray and Gordon Allport, who are to conferences on motivation what Ted Williams and Stan Musial are to all-star ballgames, there are contributions by Raymond Cattell, Leon Festinger, Irving Janis, George Kelly, George Klein and Roy Schafer.

On The Nightmare. By ERNEST JONES. 374 pages including index. Paper. Grove (Evergreen). New York. 1959. Price $1.95.

Ernest Jones' book, *On the Nightmare,* is the re-publication of a psychoanalytic classic. It discusses not only the nightmare itself but folklore and superstition related to the nightmare's themes. The book is one which belongs in any psychoanalytic library. It is of interest also to any psychoanalytically-oriented student of human institutions.

Symbolic Logic and **The Game of Logic.** By LEWIS CARROLL. 199 pages including index, and 96 pages. Paper. Dover. New York. 1959. Price $1.50.

Pillow Problems and **A Tangled Tale.** By CHARLES L. DODGSON and by LEWIS CARROLL. 109 pages and 152 pages. Paper. New York. 1959. Price $1.50.

When Lewis Carroll was not exploring the child-world he made his own, he was Charles Lutwidge Dodgson, mathematician and instructor at Oxford.

The four books reprinted here are "collaborations" between Carroll and Dodgson. They are excursions into fantasy in which Carroll took Dodgson with him. Dodgson was official author of one, *Pillow Problems*, and appears to have regretted it. All four are of psychological and historical interest and are of value besides to those who like mathematical entertainment. Dodgson was not a great mathematician but he was an adequate one and Carroll was a supreme entertainer. In *Pillow Problems*, Dodgson remarks that he has written for persons with ordinary powers of mental calculation, saying that his own are by no means extraordinary. (The reviewer has mental reservations here as to the meaning of "extraordinary.") The reader with a mathematical turn of mind may amuse himself by testing his capacity on the 72 pillow problems, which involve arithmetic, algebra, plane geometry, trigonometry, algebraical geometry, differential calculus and "transcendental probabilities."

Most psychiatric readers, however, will be more interested in Dodgson's reason for writing these problems. He intended them as mental hygiene and proposed their use for sleepless nights when, he says, one may have "mental troubles much worse than mere worry." He notes that there are "skeptical thoughts... blasphemous thoughts... [and] unholy thoughts, which torture with their hateful presence, the fancy that would fain be pure." The reader familiar with the Carroll-Dodgson personality may find material to reflect on the state of what seems to have been a man tortured relentlessly by his outraged super-ego.

St. Petersburg. By ANDREY BIELY. 310 pages. Cloth. Grove Press. New York. 1959. Price $4.75.

Biely is presented as some kind of unrecognized Russian James Joyce who was in disfavor with the official Soviet "literary line" (he died in 1934). His book deals with St. Petersburg before the revolution in 1905. It is difficult reading, as the foreword (written by George Reavey) warns: "... The reader must accustom himself to Biely's nervous style, his deliberately broken, many layered narrative, and his abstract treatment of character..."

This reviewer could not live up to these requirements, and found the book nearly unreadable.

The Mentality of Apes. By WOLFGANG KOEHLER. 293 pages and index. Paper. Vintage (Knopf). New York. 1959. Price $1.25.

This paperback book is a very neat reprint of a famous work, which is one of the basic studies in modern comparative psychology. It was first published in English some 30 years ago and it is now recognized by anthropologists as well as psychologists as a classical study. About half of the text deals with the use and making of implements, and the rest concerns behavior that can presumably be labeled pre-human. Köhler's conclusion that "chimpanzees manifest intelligent behavior of the general kind familiar in human beings," is well known. This study is of the qualitative and quantitative differences between this ape behavior and fully-developed human behavior. In this binding and at the present low price the book should be on the shelf of every student of psychology.

I Cried in the Dark. By ANN SCOTT. 192 pages. Paper. Pyramid Books. New York. 1958. Price 35 cents.

A pathetically unsophisticated report of a psychotherapy is written by a deeply masochistic woman, who, among other symptoms, developed a hysterical imitation of rheumatoid arthritis and was helped. The whole case is described in terms of hysterical rejection of femininity; the masochistic material, though clearly visible in the case history, is neglected. In this respect, the husband (a severe neurotic himself) is more perceptive than the therapist, for the former says: "You've got to be the martyr." The success achieved seems to the reviewer to be one of those in which, to keep the basis of the neurosis, the neurotic gives up some trimmings in therapy. The danger of the book is that it conveys the impression that every case of rheumatoid arthritis is curable by psychotherapy.

Teen-Agers and Alcohol. By RAYMOND G. MCCARTHY. 181 pages. Cloth. Yale Center of Alcohol Studies. New Haven. 1956. Price $4.00.

This is a handbook for educators. One can argue the point of how much should be explained to young people: "Alcoholism technically is a psychiatric condition. Attempts to interpret it in bizarre detail may be attention getting, but because such interpretations are outside the experience of young people, they are of questionable justification." But at least for educators, to whom the book is addressed, some information should be given. This is hardly the case here.

In Silence I Speak. By G. N. SHUSTER. 289 pages. Cloth. Farrar, Straus & Cudahy. New York. 1956. Price $4.50.

The story of Cardinal Mindszenty is presented by the president of Hunter College, who is principally interested in its theological-philosophical aspects. Nevertheless, the basic facts of the infamous misuse of power by the Communistic government in Budapest which staged the Mindszenty trial, emerge.

Five Ideas That Change the World. By BARBARA WARD. 188 pages. Cloth. Norton. New York. 1959. Price $3.75.

Five Ideas That Change the World is a collection of lectures by a well-known British authority on economics and international affairs. They were delivered at the University College of Ghana, the higher educational institution of one of the world's newest nations. The author takes up in very brief summary the topics of nationalism, industrialism, colonialism, Communism and internationalism. She is an eloquent spokesman for the freedom of man and the freedom of the intellect, and her book is worth the attention of any social scientist.

The Autobiography of Charles Darwin and Selected Letters. FRANCIS DARWIN, editor. 365 pages including index. Paper. Dover. New York. 1958. Price $1.65.

This work on Darwin is a reprinting of an autobiographical sketch, accompanied by a collection of important and revealing lectures, originally published more than 65 years ago. The editing is by Darwin's son, and the collection is illuminating on a number of points. For instance, Darwin makes plain his attitude toward religion, which is frequently misrepresented. This is a basic book in the field of scientific biography and belongs in every scientific library.

Man's Journey Through Time. By L. S. PALMER. 184 pages including index. Cloth. Philosophical Library. New York. 1959. Price $6.00.

Man's Journey Through Time is written by a physicist on a subject that he suggests calling anthropochronology. It is an attempt to establish a reliable chronology from the earliest periods of man down through European prehistory. The project involves both paleoanthropology and archeology, besides a discussion of human evolution and its trends. The material in this volume appears for the most part to be generally accepted. The presentation is unusually clear. The work is thus of value for any social scientist. The social scientist also will be interested in the evidence the author presents that human physical evolution is proceeding at an exceedingly rapid rate.

The Art of Listening. By DOMINICK A. BARBARA, M.D. 201 and VII pages, with index. Cloth. Thomas. Springfield, Ill. 1958. Price $5.50.

This sound and sensible book deals with a dynamic art; the provision of a keener and broader understanding of the science of listening. It shows how and where listening skills can be properly developed and effectively utilized, and cites examples of communicative behavior as they appear in everyday and clinical situations.

This sound, well-documented and comprehensive book can be practical and helpful to all who are interested in language and communication.

Heiress of All the Ages. By WILLIAM WASSERSTROM. 157 pages including index. Cloth. University of Minnesota Press. Minneapolis. 1959. Price $4.00.

Heiress of all the ages is the ideal American girl as reflected in the literature of the last 70 or 80 years. Wasserstrom says: "American writing is strewn with corpses of men and women who could not resolve the paradoxes or transcend the tensions of love. The dead are not victorious. The triumph goes to all the lustrous young women who combine magnetism and prudery..." The author thinks that American writing has identified women with society and infused them both with the Messianic idea. His discussion is from the point of view of literature and literary thought. It is an excellent literary essay and, insofar as literature reflects an ego ideal, it is well worth wider attention.

The Transcendentalist Ministers. By WILLIAM R. HUTCHISON. 240 pages including index. Cloth. Yale University Press. New Haven. 1959. Price $4.50.

Hutchison's book is a somewhat pedestrian review of a liberal religious movement of around a century ago. The book covers the little-known conflict within the ranks of the Unitarians between "biblical faith" and a liberalism based on the advance of science.

The account is of value in that it chronicles the principal events of a movement which was of far more than sectarian influence. The author does not attempt to ascribe motivation other than to rational sources.

The Growth of Modern Thought and Culture. By HERBERT WENDER. 213 pages. Cloth. Philosophical Library. New York. 1959. Price $3.75.

This is a brief account of modern thought and culture from the Renaissance to the present "age of anxiety." It includes economic changes, literature, art, science, religion, philosophy, politics, etc.

The author pleads that "intellectual freedom need not perish and cultural progress will not necessarily cease," even though we may be approaching the Hellenistic stage of development.

As the accounts are necessarily brief and summarized, this is not a book for serious scholars.

Lochinvar. By GRAHAM PORTER. Unpaged. Cloth. Crowell. New York. 1959. Price $2.95.

Lochinvar is a dog's-eye view of the velvet toreadors, the martini "olive disposal project" and the gentlemen callers of Mrs. Rippingham Cavanaugh III, "I call her Mumsy She insists on it." Whether this is very gentle or very savage satire, probably depends on the individual human's, not dachshund's, point of view. Psychiatrically-sophisticated readers, as well as practically everybody else, should enjoy it.

Textbook of Psychiatric Nursing. 5th edition. By ARTHUR P. NOYES, M.D., EDITH M. HAYDON, R.N., A.M., and MILDRED VAN SICKEL, R.N., M.S. VIII and 415 pages. Cloth. Macmillan. New York. 1957. Price $4.75.

This is a concise, well-written book, an excellent text in which very short summaries at the ends of the chapters are extremely useful. There is very little material regarding the tranquilizers and their place in psychiatric treatment, a fact many will consider a weakness.

Theory of Psychoanalytic Technique. By KARL MENNINGER, M.D. 206 pages including index. Cloth. Basic Books. New York. 1958. Price $4.75.

Karl Menninger has drawn on his 40 years of clinical and supervisory experience to write a very practical and highly readable book. Although this is a technical work based on his lectures to students of the Topeka Institute for Psychoanalysis, there is much that is stimulating and enlightening for the reader with only a general understanding of psychoanalytic principles.

Menninger discusses, simply and concisely, various technical approaches toward psychoanalytic treatment, paying particular attention to the problems which are likely to face the student preparing for psychoanalysis as a profession. Chapters on regression, transference and counter-transference, resistance, and termination of analysis offer the young analyst not only understanding of the treatment situation but also many practical recommendations for the handling of this two-party contract.

The Problem of Delinquency. By SHELDON GLUECK. 1183 pages including index. Cloth. Houghton Mifflin. Boston. 1959. Price $10.50.

The Problem of Delinquency is a survey and a collection of source material involving numerous disciplines from social work and sociology to law, penology and statistics in their relation to juvenile delinquency. The book is a competent, thorough job—of use for reference or for collateral reading in a course of law, education, psychology, social work, or psychiatry. There are articles relating the experiences and expressing the opinions of workers in all these disciplines. The role of religion is also represented by material from chaplains and marriage counselors. The volume covers such divisions of its general subject as incidence; anthropological theories, ranging from Lombroso to Sheldon and Eleanor Glueck; psychiatric and psychoanalytic theories and treatment; family life; juvenile courts; sentencing and treatment; treatment devices and techniques; and prevention. The reviewer thinks it should be on the library shelves of all schools dealing with delinquents, and of all child guidance clinics and hospitals treating mentally or emotionally disturbed children.

Light from the Ancient Past. The Archeological Background of the Hebrew-Christian Religion. By JACK FINEGAN. xxxvii and 638 pages, with 204 illustrations, six maps, four plans, general index and index of scriptural references. Cloth. Princeton University Press. Princeton, N. J. 1959. Price $10.00.

This book is a beautiful and useful work, and one which should be of interest to all students of social and psychological science. It is a revised edition of a scholarly and competent popular survey, first published in 1946, of the ancient world of long-vanished empires and peoples in which Judaism and Christianity were born. The author is a graduate in theology of the University of Berlin and is now a Protestant minister in California. His survey is nontheological; it does not take up disputed religious issues; rather, it covers archeology and history from remote antiquity (5,000 B.C.) through early Roman imperial times, and, for Christianity (the Diaspora is barely mentioned), recounts developments up to A.D. 500. The book has been revised to cover the discovery and research since its first edition.

The student of society will find here, excellently summarized, the tremendous background created by the great nations and their clashes of empire—Babylonian, Egyptian, Assyrian, Hittite, Greek, Roman—in the midst of which Judah and Israel struggled for survival. The discussion is carefully reasoned and is along generally-accepted lines for the most part; although specialists in the subject would take issue with some of the conclusions (as they do with each other's). *Light from the Ancient East* is, on the whole, a valuable nontechnical survey of the historic bases upon which many of our beliefs, ways of thought, and forms of social and psychological organization were erected; it is an important contribution to the understanding of our world and of ourselves.

ERRATUM

Psychopathology. A Source Book. CHARLES F. REED, Ph.D., IRVING E. ALEXANDER, Ph.D., and SILVAN S. TOMKINS, Ph.D., editors. Introduction by ROBERT W. WHITE, Ph.D. 803 and xii pages, and index. Cloth. Harvard University Press. Cambridge, Mass. 1958. Price $12.50.

In the review of this book in the April PSYCHIATRIC QUARTERLY, the second sentence read: "It consists of 46 *pages* selected from the psychological and psychiatric literature . . ." It should have read: "It consists of 46 *papers* . . ."

THE QUARTERLY regrets the error and expresses the hope that readers who noted in the headline that the book contains more than 800 pages were able to recognize what the parapraxis was when they first encountered it. The book is an important secondary text, providing readings from recent periodical literature, for students of abnormal psychology, and it is important that the range of its content be understood correctly.

CONTRIBUTORS TO THIS ISSUE

SANDOR RADO, M.D. Dr. Rado is a New York psychoanalyst, and is professor of psychiatry and dean of the New York School of Psychiatry. Born in Hungary, he was educated at the universities of Budapest, Berlin and Bonn. He received the degree of doctor of political science in 1911 and that of doctor of medicine in 1915, both at Budapest. His training in psychiatry was at the Psychiatric University Hospital, Budapest.

Dr. Rado has been in psychoanalytic educational activities since 1922 when he became a member of the faculty of the Berlin Psychoanalytic Institute. He came to New York in 1931 as educational director of the New York Psychoanalytic Institute. From 1944 to 1955 he was clinical professor of psychiatry and director of the Columbia University Psychoanalytic Clinic; and, in 1955 and 1956, he was "Sandor Rado Lecturer" at Columbia. He was professor of psychiatry and director of the State University School of Graduate Psychiatry in New York City from 1956 to 1958.

Dr. Rado is author or editor of several books and numerous other psychiatric and psychoanalytic publications. He was honored with the Samuel W. Hamilton Award of the American Psychopathological Association in 1956. He is a member of the New York State Mental Hygiene Council, is attending psychiatrist at the New York State Psychiatric Institute and is consultant at Manhattan (N.Y.) State Hospital.

HARRY B. LUKE, M.D. Dr. Luke was born at Ilion, N. Y., in 1908. He was graduated from Hamilton College in 1928, and from Harvard Medical School in 1932. After internship and a residency in New Bedford, Mass., and Providence, R.I., he spent a year at Marcy (N.Y.) State Hospital, then six years in private practice in Utica, N. Y. and Wolfeboro, N. H. He returned to New York state service at Pilgrim State Hospital in 1941 where he is now assistant director in charge of the Edgewood Unit (TB). He is a diplomate of the American Board of Psychiatry and Neurology, and is a member of the American Trudeau Society.

HAROLD BESSELL, Ph.D. Dr. Bessell, born in New York City in 1926, received his bachelor's and master's degrees in psychology from the University of Miami, Florida, and his Ph.D. in psychology from Purdue. He taught at the University of Miami, interned at the Wichita (Kas.) Guidance Center, taught at Purdue and then became staff psychologist at the Wichita Guidance Center. He was chief psychologist of the Wichita Veterans Administration Mental Hygiene Clinic from 1954 to the present

year and has been in private psychological practice since 1954. He moved to LaJolla, Calif., this year and is in private practice there. Dr. Bessell is a member of the American Psychological Association and a member of the American Academy of Psychotherapy.

VINCENT E. MAZZANTI, M.D. Dr. Mazzanti has been chief of the mental hygiene clinic of the Veterans Administration at Topeka, Kas., and a member of the faculty of the Menninger Foundation School of Psychiatry. Born in Arkansas in 1917, he received his medical degree at the University of Arkansas in 1941 and, following an internship, became a fellow of the Menninger Foundation School of Psychiatry. He was on the teaching staff of the Topeka Psychoanalytic Institute from 1950 to 1957. He now is in private practice in LaJolla, Calif. Dr. Mazzanti is certified in psychiatry by the American Board of Psychiatry and Neurology. During World War II he served as battalion surgeon with an infantry regiment and holds the Purple Heart and Bronze Star.

CECIL BERESFORD, M.B., B.S., L.R.C.P., M.R.C.S., D.P.M. Dr. Beresford was educated at Christ College, Brecon, and after a short premedical course at Bristol University, entered the London Hospital Medical School (University of London) in 1926. He graduated in 1931, obtaining both the medical degree of the London University and the diplomas of the Royal Colleges of Medicine and Surgery of England in that year. After further postgraduate general medical experience as resident at the Southend (Essex) General Hospital, he began his training in psychiatry at Netherene Mental Hospital, Coulsdon. Upon its completion he joined the staff of The Retreat at York as senior assistant psychiatrist, a position he held until World War II. During the war he served for nearly five years with the R.A.M.C., at first as regimental medical officer and later as psychiatric specialist with the 5th Western General Hospital. He was subsequently promoted to lieutenant-colonel when appointed adviser in psychiatry to the Middle East Land Forces, a position he held until the end of hostilities.

He returned to The Retreat after demobilization as consultant in psychiatry and became clinical director in 1951. He has been physician superintendent since 1956.

As well as being the administrative head of The Retreat, now one of the private psychiatric hospitals independent of the National Health Service, he serves on the management committee of a group of state hospitals and on the medical advisory committee of a state psychiatric hospital. He is an active member of the Royal Medico-Psychological Society and Vice-President of the Leeds Regional Board Psychiatric Association.

DANIEL CAPPON, M.B., M.R.C.P., D.P.M. Dr. Cappon was educated in England. His medical schools were those of the University of London and of St. Mary's Hospital. His diplomate in psychological medicine is English, and his M.R.C.P. is at Edinburgh. He is certified in psychiatry by the College of Physicians and Surgeons of Canada. Dr. Cappon served from 1945 to 1948 in the Royal Army Medical Corps in the United Kingdom and in the Far East; he was a specialist in medicine and psychiatry and was in charge, in his later service, of the psychiatric division of 300 beds in the military hospital in Poona, India. After leaving the army, he was postgraduate registrar at the Maudsley Hospital, University of London, and later at Guy's Hospital, London.

Dr. Cappon became a staff member of the department of psychiatry at the University of Toronto in 1950 and entered private practice in Toronto at that time. He had a Jungian training analysis in London before going to Canada. Dr. Cappon directed a child and adolescent guidance center for York Township, Ontario, from 1951 to 1955. He became research associate at Toronto General Hospital in 1955 and was consultant psychiatrist for Northwestern General Hospital in the same city during 1955 and 1956. In 1958 and 1959 he was chairman of the section of neurology and psychiatry of the Academy of Medicine, Toronto. He has been lecturing and teaching social workers, psychologists, nurses, medical students, and postgraduate students in psychiatry for the past 10 years. He is author of a number of medical, psychiatric and analytic works. Dr. Cappon is married and has four children.

MOSES ZLOTLOW, M.D. Dr. Zlotlow, born in Poland in 1906, received his M.D. from the Medical School at Bari, Italy, in 1935. During World War II, from 1942 to 1945, he was in various German concentration camps. In 1946, he came to the United States and, after internship, was on the Pilgrim (N.Y.) State Hospital staff from 1949 until October 1958, when he moved to Middletown (N.Y.) State Hospital as supervising psychiatrist. He is on the neurological staffs at Bellevue Hospital, Beth Israel Hospital and Hillside Hospital. He is a member of the American Psychiatric Association and the New York State and Orange County Medical Associations.

ALBERT E. PAGANINI, M.D. Born in Brooklyn in 1920, Dr. Paganini received his B.S. from St. Francis College in Brooklyn in 1941, and his M.D. from Georgetown University School of Medicine in 1944. He had rotating internships at St. Catherine's Hospital, Brooklyn, and St. Vincent's Hospital, Staten Island, then was in private general practice from 1947 to 1951. He was in military service during the Korean War from

1951 to 1953, during which time his interest and training in psychiatry began. He has been at Pilgrim (N.Y.) State Hospital since 1953. At present, he is a supervising psychiatrist. Dr. Paganini is a member of the American Psychiatric Association and other professional organizations.

RICHARD N. KOHL, M.D. Dr. Kohl is a graduate of the University of Cincinnati, where he received his bachelor's degree in 1938 and his M.D. in 1942. A resident psychiatrist at the Payne Whitney Clinic of the New York Hospital from 1944 to 1949, he is now full-time assistant professor of psychiatry at Cornell Medical College. He is an expert examiner in psychiatry for the Municipal Civil Service Commission of New York City. He is a commander in the naval reserve and served from 1954 to 1956 at the United States Naval Hospital, Bethesda, Md. He is a member of the American Psychiatric Association.

MARVIN K. OPLER, Ph.D. Dr. Opler is professor of social psychiatry at the University of Buffalo School of Medicine, and professor of sociology in the graduate division of the university. He is associate editor of *The International Journal of Social Psychiatry*. He is author of *Culture, Psychiatry and Human Values* and editor of *Culture and Mental Health—Cross Cultural Studies* (Macmillan 1959), as well as co-author of various earlier books on anthropological and psychiatric subjects.

Dr. Opler's undergraduate work was at the University of Buffalo and the University of Michigan; his doctorate is from Columbia University. He both attended, and lectured at, the Psychoanalytic Institute of Los Angeles. He has taught at Harvard in the department of social relations, and at Stanford University. From 1952 to 1958, he was at the Cornell University Medical College department of psychiatry (with Dr. Thomas A. C. Rennie in social psychiatry). Special lectureships besides that at the Los Angeles Psychoanalytic Institute, have been at the William Alanson White Foundation in New York, the New School for Social Research, and the graduate school, department of psychology, at Clark University. His studies of cultural backgrounds of the schizophrenias, begun 20 years ago at Morningside Clinic and Hospital, were continued while he was associated with Dr. Rennie as a principal researcher in other epidemiological studies of psychiatric disorder in New York City.

IAN C. FUNK, M.D. Dr. Funk, born in New York in 1915, was attending medical school in Paris when World War II caused his transfer to the Albany Medical College, from which he was graduated in 1942. After

a year's internship, he entered the army in 1943 and was retired in 1946. He was a resident in psychiatry at Albany Hospital for a year and had two years of residency in psychiatry at Cushing Veterans Administration Hospital. He was staff psychiatrist at Bedford Veterans Administration Hospital from 1950 to 1952 and then became chief of the psychiatry service at the Albany Veterans Administration Hospital and associate professor at Albany Medical College in the department of psychiatry. Dr. Funk is now in private practice. He has been much interested in work aiming to change the regression of chronic psychotic patients and the general attitude toward them, an interest reflected in his contribution to this issue of THE QUARTERLY.

PHILIP S. HERBERT, JR., M.D. Dr. Herbert is a graduate of Cornell, from which he received his A.B. in 1947 and his M.D. in 1951. He interned at the Cornell Medical Division of Bellevue Hospital, New York City, and took his residency training in psychiatry at the New York Hospital—Westchester Division. After a year as senior assistant psychiatrist at the New York Hospital, he went into private practice. Dr. Herbert was born in New York City in 1923 and was brought up in a New Jersey suburb. He served as an enlisted man and as a junior officer in the field artillery during World War II. Dr. Herbert notes that the artistic and literary interests which are "obvious" in his choice of the research problem he reports in this issue of THE PSYCHIATRIC QUARTERLY, began at an early age.

EUGEN KAHN, M.D. Eugen Kahn, born in 1887, received his medical degree at Munich in 1911. He is professor of psychiatry at Baylor University College of Medicine, Houston, Texas, is a member of the American Psychiatric Association, and is certified in both psychiatry and neurology by the American Board of Psychiatry and Neurology.

Dr. Kahn studied at the University of Heidelberg and at the University of Berlin, before studying medicine at Munich. His postgraduate training included internship, residency, and eight years as chief of staff of the medical clinic, University of Munich. For six years of this period, he had also been chairman of the staff of the neuropsychiatric clinic at that university. He came to this country as assistant professor of psychiatry at Yale in 1927, and he became professor of psychiatry and mental hygiene there and psychiatrist-in-chief of the New Haven (Conn.) Hospital in 1930. He was Sterling clinical professor of psychiatry at Yale from 1946 to 1948, and since 1948 has been a research associate at Yale. He became professor of clinical psychiatry at Baylor in 1951 and has been professor of psychiatry since 1954.

NEWS AND COMMENT

MEETINGS AND LECTURES ARE ANNOUNCED

The Academy of Psychosomatic Medicine is conducting its annual meeting in Cleveland, October 15 to 17, 1959. The meeting, the Academy announces, has been specifically planned for the psychosomatic orientation of the general practitioner, internist, pediatrician, obstetrician and other non-psychiatric practitioners.

The Academy of Psychoanalysis announces its midwinter meeting will be held on December 5 and 6 in New York City. The first day's meeting will be devoted to consideration of psychoanalytic concepts in allied fields, and the second day will be devoted to clinical papers.

The twenty-seventh series of the Thomas William Salmon Lectures will be given on Wednesday, December 2 at the New York Academy of Medicine. Curt Paul Richter, Ph.D., professor of psychobiology at the Johns Hopkins Medical School will be this year's Salmon lecturer on the subject of "Biological Clocks in Medicine and Psychiatry."

The American Psychosomatic Society will conduct its seventeenth annual meeting on March 26-27, 1960 in Montreal. At this year's annual meeting in Atlantic City in May, Eric B. Wittkower, M.D., took office as president, Morton F. Reiser, M.D., became president-elect, and Eugen Meyer, M.D., became secretary-treasurer.

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DR. FINESINGER, J.N.M.D. EDITOR, DIES

Jacob E. Finesinger, M.D., editor of the *Journal of Nervous and Mental Disease,* and professor of psychiatry and head of the department of the University of Maryland School of Medicine, died June 19, 1959 after a year's illness. Dr. Finesinger was a graduate of the Johns Hopkins University where he received his bachelor's degree and a master's degree in zoology, in addition to his M.D., which he obtained in 1929. He interned and took a residency in neurology in Boston, then became connected with the Harvard Medical School where he remained until he joined the University of Maryland School of Medicine faculty in 1950.

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PILGRIM (N.Y.) STATE HOSPITAL DIVIDES INTO UNITS

Pilgrim (N.Y.) State Hospital, often called the largest mental institution in the world, is being divided into units which will operate as smaller hospitals within the 14,000-bed institution. The plans, worked out by Henry Brill, M.D., recently appointed director at Pilgrim, are in the form of a pilot project according to New York State Commissioner of

Mental Hygiene Paul H. Hoch, M.D. The sub-units will have 2,000 to 3,000 beds each; two have already been established and five more are projected. Each will be under the management of an assistant director and each will have its own admission service, treatment facilities and release procedure. Dr. Hoch points out that the establishment of smaller hospital units within a large hospital has been practised successfully in Denmark and elsewhere; and the Pilgrim project is expected to test the application of the idea to a large state hospital system.

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EMIL A. GUTHEIL, M.D., DIES AT 60

Emil A. Gutheil, M.D., widely known as the official translator of the works of Wilhelm Stekel, and editor of the English edition of Dr. Stekel's autobiography, died on July 17, 1959 at Mount Sinai Hospital, New York City. Dr. Gutheil was supervising psychiatrist of the Postgraduate Center for Psychotherapy and was its director of publications. Born in Poland, he was graduated in medicine from the University of Vienna in 1930. He was the author of *Language of the Dream* and the *Handbook of Dream Analysis.*

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BARNARD EXPERIMENTAL COURSE HAILED

The five Barnard College students who have just completed an experimental clinical psychopathology course offered jointly by Barnard and the Payne-Whitney Clinic of the New York Hospital, have expressed approval of the course, according to an announcement issued by the college. This is the first public announcement of the course, although it has been given for four years. The college announcement says that of the 17 students who have taken it, 13 are continuing in the field of clinical psychology, either working or studying or both.

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DR. GRANTLY DICK READ DIES AT 69

Dr. Grantly Dick Read, author of *Childbirth Without Fear*, and widely known as a writer of other material and as a lecturer on "natural childbirth," died at his home in Roxham, England, on June 11, 1959. Dr. Read was widely known in American psychiatric circles where his theories attracted considerable professional attention.

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NEW JOURNAL ON "TRANQUILIZERS" ISSUED

The first issue of *Psychopharmacologia*, a journal devoted to the "tranquilizing" drugs, is being issued by Springer-Verlag in Berlin. Six of the seven articles of the first issue are in English; the other is in French. A review of the first issue appears in the book review section of this QUARTERLY.

ABRAHAM STONE, M.D., BIRTH-CONTROL LEADER, DIES

Abraham Stone, M.D., widely known in psychiatric circles because of his position as a world leader in the birth-control movement and in marriage counseling, died in New York City on July 3, 1959 at the age of 68. Dr. Stone, a urologist, was, with his late wife, Dr. Hannah M. Stone, one of the early leaders of the international birth-control movement. His interest in marriage counseling, in which his wife also took part, led to the establishment of the Marriage Consultation Center of the Community Church of New York, a center often regarded as a model of its type. Dr. Stone's most recent book was *Planned Parenthood*, written with Dr. Norman Hines.

A. P. A. REJOINS HEALTH COUNCIL

The American Psychiatric Association has rejoined the National Health Council, following a vote of the council of the psychiatric association on May 1, 1959. The American Medical Association and the American Hospital Association are other recent additions to the membership of the National Health Council, which now numbers 66 national organizations.

PILOT COMMUNITY PROJECT SET UP

A pilot community treatment service for the mentally ill is being set up at Hudson River (N.Y.) State Hospital with a Milbank Memorial Fund research grant of $250,000 available to finance a five-year demonstration project. The new enterprise, announced by Robert C. Hunt, M.D., director of Hudson River State Hospital, will serve the residents of Dutchess County, where the hospital is located in the city of Poughkeepsie. One building within the hospital is being converted to the care of the more than 600 Dutchess County patients, for whom a full staff will be provided. As a second stage of the project, "precare" service will be made available for consultation by physicians, police and others concerned with the hospitalization of the mentally ill. This service may recommend treatment by the family physician, referral to a practising psychiatrist or a psychiatric out-patient clinic, treatment at Hudson River's day hospital, or admission to the hospital itself as an in-patient. Dr. Hunt believes that "precare" measures can keep some patients out of the hospital altogether and that they will assure better attitudes and consequently better response to treatment on the part of patients who are finally admitted.

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